PACT Training Programs for PACT Teams
PACT Demonstration Lab Cyberseminar
March 20, 2013

Carole Warde MD

VISN 22 Veterans Assessment and Improvement Laboratory

Anneliese Buttler MSW

VISN 4 Center for Evaluation of PACT

What aspects of PACT training would you like to learn from this Cyberseminar?

a) Curricular content to train teamlets in PACT principles

b) Strategies to help teamlet members work together as a team

c) Innovative models for PACT training and spread

d) Frontline staff perspectives on PACT training (effectiveness, suggested improvements)

e) General knowledge of how other VAs are training for PACT

What is your perspective for learning?

a) Clinical Content – what is in the curriculum?

b) Operations – how to put on a PACT training seminar?

c) Research – how to study the effectiveness of a PACT training seminar?

Team Communication Exercise "TEX"

Development of an Intervention to Improve and Teach Team Function

Carole Warde MD and Marjorie Pearson PhD

PACT Demonstration Lab Cyberseiminar

March 20, 2013

TEX Aim

We aimed to develop an interactive practice-based coaching program to assist PACT teamlets with trainees to learn, practice and coach effective team function.

TEX Presentation Outline

1. The Conceptual Model
2. The Pilot Curriculum Planning
3. The Pilot TEX Intervention
   a) Sample Session Outline
   b) Coaching Methods
4. Formative Evaluation Plan
5. Lessons Learned: Curriculum
6. Lessons Learned: Implementation
7. Key Recommendations to Improve TEX
8. Conclusions

1. TEX Conceptual Model

Team Function

TASK WORK:

Quality Improvement

1. Set aims
2. Identify problems
3. Establish measures
4. Select changes
5. Test changes using PDSA cycles
6. Implement changes

TEAM WORK:

Relationships

1. Listen actively
2. Build trust
3. Manage emotions
4. Make decisions by consensus
5. Define roles
6. Hold accountable
7. Give feedback
8. Receive feedback
9. Support change in others

2. Pilot TEX Curriculum Planning

Tools Were Developed for
Coaching and Evaluation in 3 Curricular Areas

- Needs assessment tools
- Post-intervention evaluation tools
- Teaching Materials
  - QI and Team Meeting Process handouts
  - Communication behavior pocket cards
  - Interactive learning models and exercises

3. Pilot TEX Intervention

- **Two volunteer teamlets with trainees** at two VA sites in Southern California
- **Two coaches** facilitated the learning sessions
- **Five onsite workshops** with all teamlet members
  - 1 Engagement Session (Administrators also attended)
  - 1 Observed Needs Assessment
  - 2 Coached Interactive Workshops
  - Final Discussion and Evaluation
- **4 coaching calls** with teamlet leaders only

Sample Workshop Outline: Overview

Objective: Identify the 3 aspects of team function

- Task work related to Quality Improvement (QI)
  – Rationale for QI
  – IHI QI Process

- Team Processes – Effective Team Meetings
  – Ground Rules
  – Guide for team meetings
  – Member roles during team meetings

- Team Work – Relationship-centered team communication
  – Lessons learned from the NDP

Coaching Practices Emphasized Motivation, Education and Consultation

- Mindfulness practices
- Appreciative reflection
- Active listening exercises
- Emotional management skills
- Stress-management awareness and management
- Paired discussions
- Facilitated large-group discussions and team meetings
- Role-modeling of relationship behaviors
- Role-plays
- Didactic presentations of relevant models and skills

4. Formative Evaluation to Assess and Guide TEX Improvement

- **Participants and Coaches assessed:**
  - Reactions to TEX curriculum and implementation
  - Behavior change in each of the three areas
- **We collected evaluation data in several ways:**
  - Immediate participant feedback at the end of each session
  - Immediate coaches' discussion and documentation
  - Reflective coach observation summary and recommendations
  - Participant end of course survey assessment
  - Coach group discussion and consensus to determine lessons learned and recommendations

5. Lessons Learned: TEX Curriculum

- **The Triple Focus worked**
  - Teamlets had needs and improved in all 3 areas
- **Team Meeting Processes were essential**
  - Mastery of these first facilitates learning in other areas
- **Team Communication Skills needed more**
  - More time and practice is needed in all behaviors
- **Quality Improvement was a struggle**
  - A challenge from mindset to measurement
  - Work-flow redesign pushes teams to improve team function

6. Lessons Learned: TEX Implementation

- **Coaching was appreciated**
  - Teamlets responded to coaching in all three areas
  - A number of coaching methods were successful
  - Teamlet dysfunction needs immediate response
- **The pilot structure worked**
  - The onsite, teamlet directed course was well-received
  - Both the interactive sessions and coaching calls were useful
- **Including trainees was a "win-win"**
  - Trainees benefited from active involvement in TEX
  - Teamlets benefited from the trainees' time, curiosity and fresh skills

7. Key Recommendations to Improve TEX

Curriculum

- Emphasize relationship-centered meeting processes early
- Allow more time for coached communication and QI skills
- Involve administrators to motivate and support QI
- Introduce ideas for change involving work-flow re-design

Implementation

- Alternate sessions and calls every 2 – 3 weeks
- Emphasize ongoing needs assessment and feedback
- Intensify coaching in trust-building, identification and management of teamlet dysfunction, and teamlet leadership

8. Conclusions

- The Triple-Focus model is useful to improve and teach teamwork

- The interactive TEX curriculum helped PACT teamlets with trainees improve team function

- Our assessment tools and processes provided meaningful feedback to direct future sessions

- We expect the recommended revisions to further strengthen the TEX innovation

Acknowledgement

VISN 4 Virtual PACT Collaborative 1.0: Successes, Challenges, & Lessons Learned

Anneliese Butler, MSW

March 20, 2013

Acknowledgements

Project Team:

- Anneliese Butler, MSW
- Anne Canamucio, MS
- Michele Lempa, DrPH
- Mary Pelak, MSW
- Gala True, PhD, Co-Director Qualitative Evaluation Core

Partners:

- David Macpherson, CMO
- Jennifer Skoko, AO to CMO
- VISN 4 Virtual Collaborative Steering Committee
- Virtual Collaborative participants and coaches

With the support of:
Rachel Werner, MD, PhD, CEPACT Director
Judith Long, MD, Associate Director
Judy Shea, PhD, Director of Qualitative Evaluation Core

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VC Evaluation - overview

- **Focus & approach:**
    1. **Implementation process**
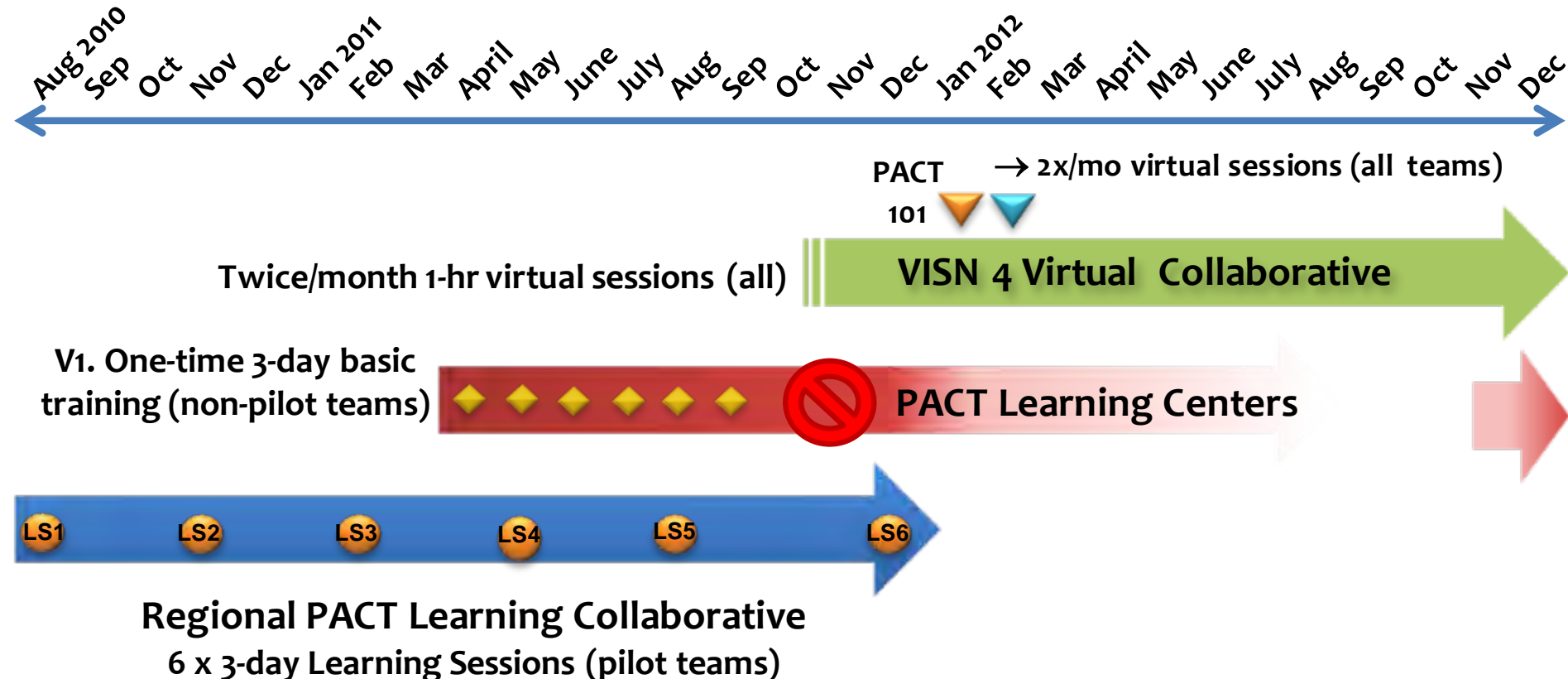   - What did it take to implement the model?
        - How did implementation vary between sites?
        - How did the model evolve over time?
        - **Methods:** process diary and interviews with key contacts
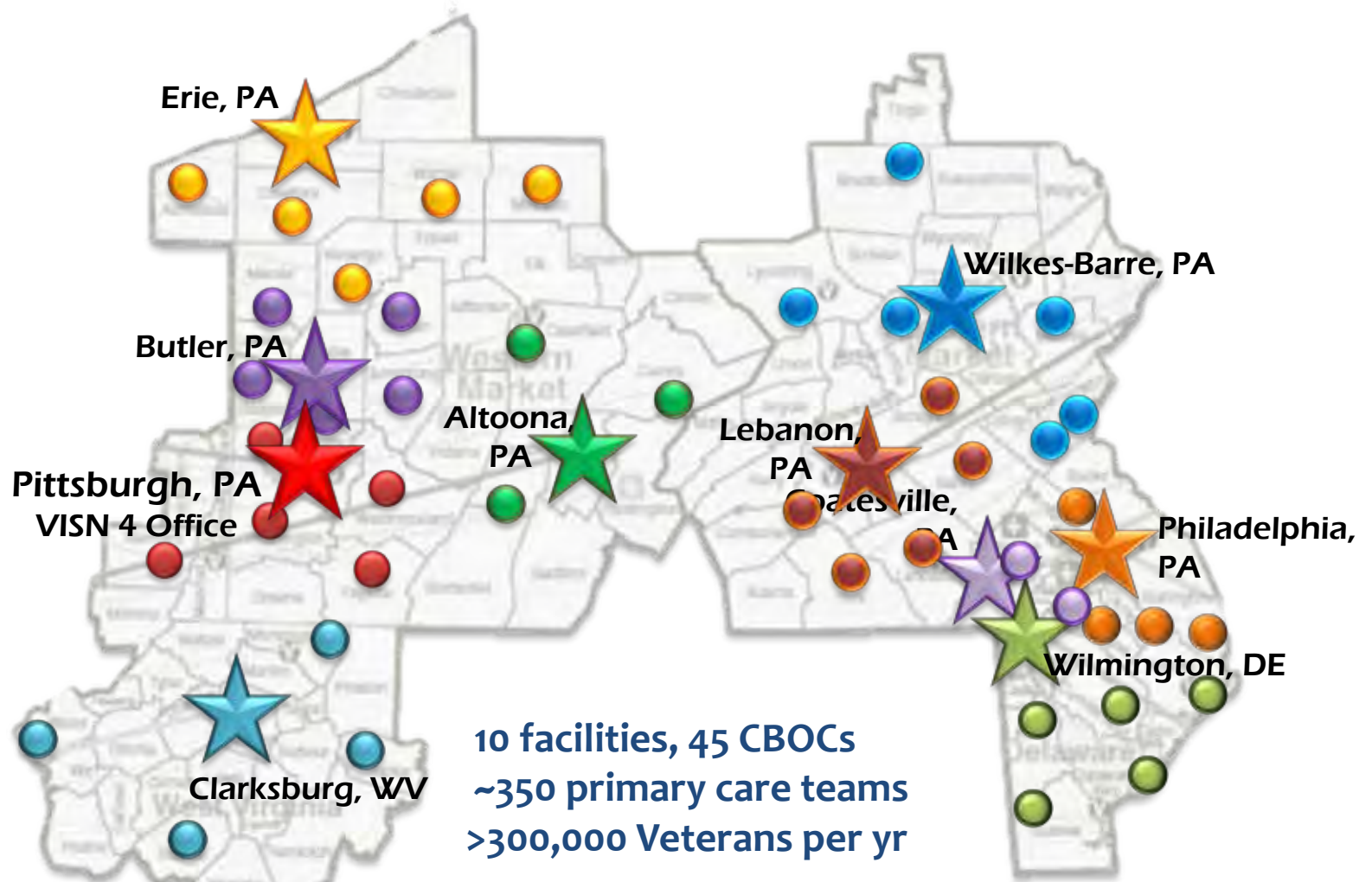   2. **Learners' experiences**
        - Was the VC successful from the perspective of the teams?
        - What worked, for whom, under what conditions?
        - **Methods:** anonymous survey, key contact interviews

VC History
Why another PACT training?

Aug 2010 — Sep — Oct — Nov — Dec — Jan 2011 — Feb — Mar — April — May — June — July — Aug — Sep — Oct — Nov — Dec — Jan 2012 — Feb — Mar — April — May — June — July — Aug — Sep — Oct — Nov — Dec

PACT 101 → 2x/mo virtual sessions (all teams)

Twice/month 1-hr virtual sessions (all)   **VISN 4 Virtual Collaborative**

V1. One-time 3-day basic training (non-pilot teams)   **PACT Learning Centers**

LS1   LS2   LS3   LS4   LS5   LS6

Regional PACT Learning Collaborative
6 x 3-day Learning Sessions (pilot teams)

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★ vaHealthcare VISN 4

VISN 4

Erie, PA

Wilkes-Barre, PA

Butler, PA

Altoona, PA

Lebanon, PA

Coatesville, PA

Philadelphia, PA

Pittsburgh, PA
VISN 4 Office

Wilmington, DE

10 facilities, 45 CBOCs
~350 primary care teams
>300,000 Veterans per yr

Clarksburg, WV

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VC model ~ online elements

Virtual learning sessions
- via Live Meeting 2x/month, 12-1pm
- Schedules blocked per VISN directive

Erie, PA

Wilkes-Barre, PA

Butler, PA

Altoona, PA

Lebanon, PA

Pittsburgh, PA
VISN 4 Office

Coatesville, PA

Philadelphia, PA

Wilmington, DE

Clarksburg, WV

VC SharePoint
- VC archives
- Recorded sessions
- Tools & resources
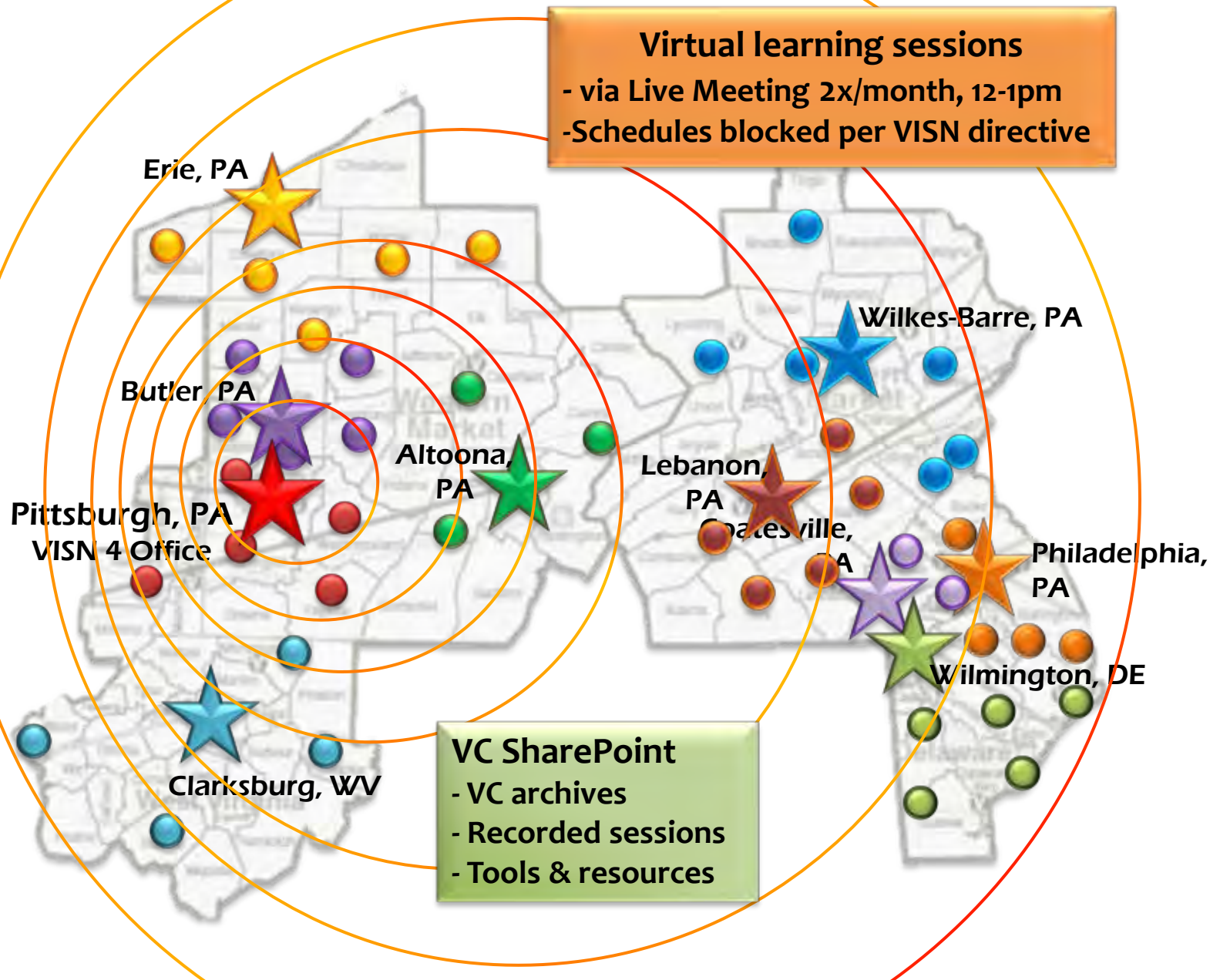
VC model ~ "offline" elements
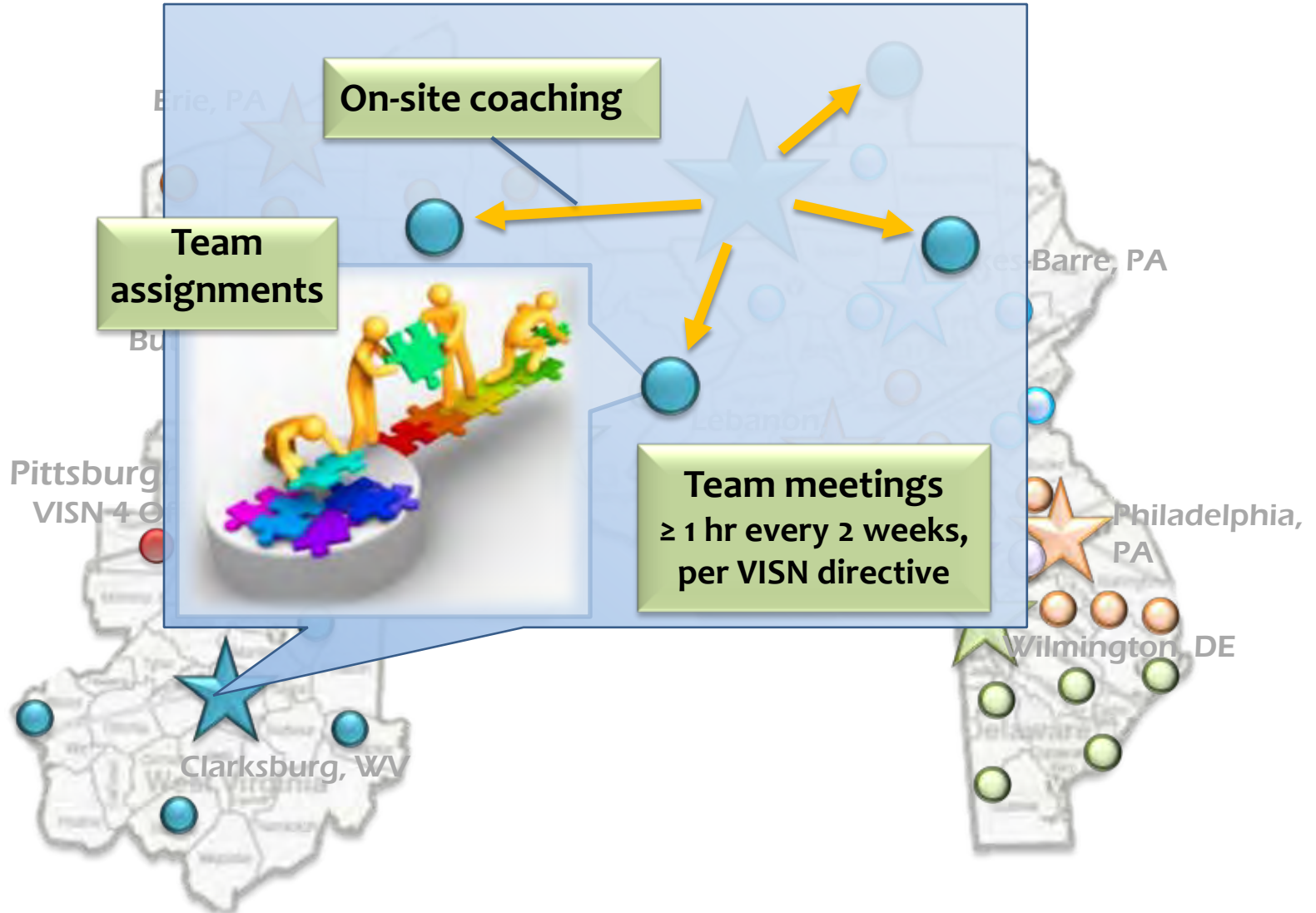
VC Schedule/Curriculum (first 9 months)

Jan 5 & 19   PACT 101 (for teams with no prior PACT training)

Feb 2   Introduction to VC and details of PACT metrics

Feb 16   The inpatient outpatient transition

Mar 1   Chronic Pain Management (providers only)

Mar 15   "Hot spots" – Patients at high risk for admission

Apr 5   Advanced clinic access

Apr 19   Diabetes Management (providers only)

May 3   Telephone care

June 7   Update in General Internal Medicine (providers only)

June 21   Team Care – working in a team

July 5   Where do we stand? Current status of PACT implementation

Aug 2   Team Presentations – 4 teams present frontline perspective

Aug 16   PACT team roles – top of license and new roles

Sep 6   Pain Management - caring for opioid misuse (providers only)

Sept 20   Palliative Care

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Virtual Collaborative - Survey of Learner Experiences (Round 2)

Final thoughts

7. Please use the space below for any any additional comments about the Virtual Collaborative that you would like us to relay to VISN 4 Leadership.

> ➢ Anonymous, brief (5 min), 38 items (incl. 4 open-ended)
> ➢ Target group: Core team members (PCPs, RNs, Clinical & Clerical Associates)
> ➢ Fielded twice during first 9 months (April & September)

You have reached the end of the survey. Thank you again for taking the time to share your feedback!

100%

Previous   Done

Powered by **SurveyMonkey**
Check out our sample surveys and create your own now!

Survey aims

1. Determine **extent of participation** in VC activities (virtual learning sessions, team meetings, etc.).

2. Assess learners' perspectives on the **usefulness** and **value** of each VC activity/component and of the VC as a whole.

3. Gauge learners' perceptions of VC's overall **impact** on PACT-related knowledge and access to resources.

4. Assess **acceptability of the VC format** relative to prior PACT training initiatives.

…and identify differences by role, site, facility type, prior exposure to PACT trainings, and extent of participation in VC (for aims 2-4)

Respondent characteristics

	Round 1	Round 2
Survey Response rate:	41% (335/819)	43% (353/820)
Role:		
PCPs	34%	39%
RN/Care Managers	28%	25%
Clinical Associates	18%	17%
Clerical Associates	7%	5%
Facility type:		
VAMC	52%	48%
Training exposure:		
Had prior PACT training	33%	35%

Highlighted findings*

Participation/Engagement:

Good attendance of virtual sessions; team meetings shorter than intended, possible erosion over time

Perceived usefulness & impact:

Virtual sessions & team meetings valued; "HW" unpopular

Benefits: Increased knowledge, perspective, access to tools & resources, learning from peers across VISN

Factors associated with perceived benefits:

Exposure to prior PACT training
Full participation in all VC activities

* Complete survey report available upon request

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"What was useful?"

"I like to **see what others are doing** so we know other ways to implement and use PACT." (Nurse Manager, VAMC)

"It **helps to understand how the PACT teams are functioning** both at our facility and in VISN in general." (PCP, VAMC)

"**increased understanding of** how individual factors come together to form one **big picture**" (Clinical Associate, CBOC)

"It **gives me** the **perspective** that none of us are having an easy time putting this into practice." (Clinical Associate, VAMC)

"**reduction of travel** makes it much less of a negative impact on group and team productivity" (PCP, VAMC)

Constructive criticism: VC Content

"I think having **a training on PACT**, to get a basic understanding **prior to the VC, would have been very helpful**. All these months into it, we are just now finding out about tools to help with this process. **I feel that we are embarking on a quest without having the basic fundamentals in place first**." (Clinical Associate, CBOC)

"It seems like **the majority of them were more directed towards the provider** and not the rest of the PACT team." (Clinical Associate, VAMC)

"I am not yet fully PACT as we are quite low in RNs… The presenters of the collaborative could **give alternative ways of doing things for teams like ours** that have 1 RN for 8 providers …**instead of making suggestions for the ideal theoretical team** that we currently don't have yet." (PCP, CBOC)

Benefits limited by familiar challenges

"…Only my RN comes to the collaborative, no one else from my team … has time or has been released from work tasks. I think if we value something then we make it a priority **so if the PACT is truly a priority, set aside time away from work to let people attend**." (PCP, VAMC)

"We are so severely understaffed that going to these sessions is **like sending a diabetic to lunch at a candy store**. What's the use when you can't avail yourself of such wonderful 'theoretical' concepts. **PACT is flying overhead and we're still in the bunkers**." (PCP, VAMC)

"**going to the [VC] is torture** … I go learn about things other facilities try and do [that] we aren't allowed [to do] … **I get to hear things that the National and VISN recommend but they are ignored at this facility**." (PCP, VAMC)

"At the team level there are very few changes that can be made to implement PACT to the best of our ability – **our hands are tied by the administration!**" (PCP, CBOC)
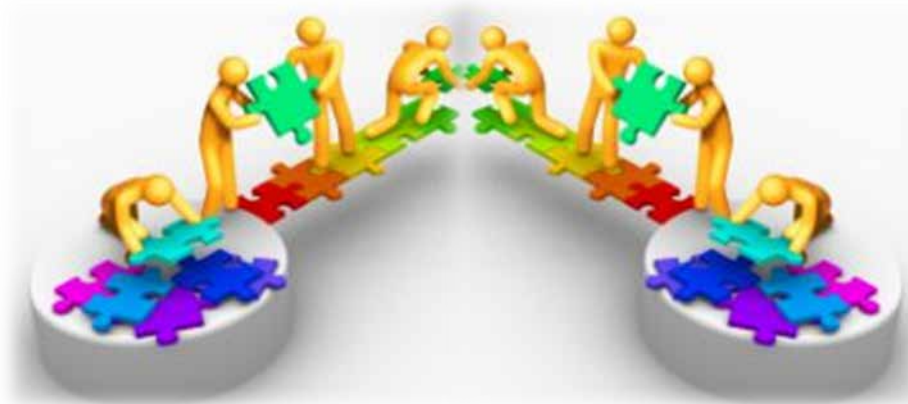
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So what?

Lessons learned & takeaways

- VC holds promise
- Insist on truly protected time
- Consider needs of <u>all</u> team members
- Match content to audience
- Speak to teams' challenges
- Confront leadership issues
- Actively seek input from "the trenches"

Virtual Collaborative 2.0

- Practice Improvement Series
  - expanded focus (beyond Compass metrics)
  - emphasis on team-based QI, less on "PACT"
  - more team autonomy

Questions?

For more information:
anneliese.butler@va.gov

VISN 4 Center for Evaluation of PACT (CEPACT)
Philadelphia VA Medical Center
3900 Woodland Ave, Bldg 4100
Philadelphia, PA 19104
http://vaww.visn4.va.gov/CEPACT/

Virtual Collaborative Survey of Learner Experiences – Final Report

VISN 4 Center for Evaluation of Patient Aligned Care Teams
Anneliese Butler, MSS
Anne Canamucio, MS
Mary Pelak, MSW
Gala True, PhD[1]

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[1] Readers are invited to submit questions and comments about the contents of this report by e-mailing Anneliese.Butler@va.gov.

Contents

I. ACKNOWLEDGEMENTS

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II. EXECUTIVE SUMMARY

The VISN 4 Virtual Collaborative (VC) was launched by Dr. David Macpherson, Chief Medical Officer for VISN 4, in January 2012 as a central part of the VISN's plan to advance Patient Aligned Care Team (PACT) implementation and spread. The Center for Evaluation of Patient Aligned Care Teams (CEPACT) partnered with Dr. Macpherson and the VC Planning Committee to assist in evaluating the VC. One component of the evaluation is a survey to assess the experiences and perceptions of VC participants at midpoint (April 2012) and again at the end of the first 9-month phase (September 2012). This report presents results and findings from Round 2 of the survey, and reflects on trends over the first year of the VC and implications for improving learners' experiences as the VC enters its next phase. Significant results for each survey aim as well as key findings are summarized below.

Survey Sample:
Forty-three percent of VC participants (n=353) responded to the second round of the survey. As with Round 1 of the survey, respondents to Round 2 were more likely to be Primary Care Providers (39%) or RN Care Managers (25%) than Clinical or Clerical Associates (17% and 5%, respectively). About one-half of respondents in each survey were located at a VA Medical Center, and about one-third had attended some form of PACT training prior to entering the VC.

Aim 1: Extent of Participation in Virtual Collaborative Activities

- Participation in Live Meeting sessions was comparable to participation at midpoint, with a majority of respondents reporting that they had attended all or most Live Meeting sessions. Respondents in Round 2 were more likely to have attended sessions alone rather than with others compared with respondents to Round 1.

- Participation did not vary significantly by facility type or exposure to prior PACT training. PCPs were more likely to have attended most Live Meeting sessions compared with RNs.[2]

- Compared to Round 1, respondents in Round 2 were less likely to report that their teams had been meeting at the expected frequency (at least once every two weeks). Exposure to prior PACT training and working at a VAMC were associated with higher team meeting frequency.

- Similar to Round 1, most respondents indicated that team meetings were shorter than originally envisioned, with only 15% stating that their teams met for the recommended hour. Respondents in Round 2 were less likely to have completed all homework assignments compared with Round 1 respondents. About one-third of respondents said their team had completed all homework assignments since the midway point, while almost half completed some or most of the assignments. Approximately half said that homework was completed as a team.

- One-fifth of respondents were considered to have participated fully in the VC between April and September; those at a VAMC and those with prior PACT training were more likely than those at a CBOC or those with no prior training to be getting the full VC experience.

Aim 2: Perceived Usefulness and Value of the Virtual Collaborative

- Over half of survey respondents found the Live Meeting sessions to be of use, especially the stories and examples from other teams. RN Care Managers were more likely to find the sessions useful, as were those who had prior PACT training and those who were highly engaged in the VC.

- A majority of respondents agreed that team meetings were useful. Team meetings were valued more highly by respondents who were stationed at a VAMC, had prior PACT training, and/or were fully engaged in the VC.

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[2] We surmise that we would have seen similar differences between PCPs and both clinical and clerical associates if the latter two roles had been more strongly represented in the overall survey sample.

- As in Round 1, homework was the least popular aspect of the VC; however respondents who were fully engaged in the VC were more likely to agree that the assignments were useful in making PACT related changes
- Of those respondents who used available resources (coaches, SharePoint, VC coordinator), those participating fully in VC activities were also more likely to rate these resources as useful.

Aim 3: Perceived Impact of the Virtual Collaborative

- A majority of survey respondents agreed that participation in the VC has positively impacted their knowledge about, awareness of, and access to further resources related to PACT. Close to one-half of respondents felt that participation in the VC was worthwhile for someone in their role, and a plurality agreed that the VC had increased communication with other teams and helped their team progress with PACT implementation.
- Respondents with prior PACT training and those who were highly engaged in the VC were considerably more likely to perceive a positive impact.

Aim 4: Acceptability of the Virtual Collaborative Format

- Over half of respondents felt the VC format was an acceptable alternative to off-site training and liked receiving training in "small doses" spread over time. Respondents to this survey were more likely than Round 1 respondents to feel that the VC offered a comparable level of training to an off-site format. However, 42% indicated that participation in the VC interfered with their day-to-day work.
- Respondents with prior PACT training and those who were highly engaged in the VC also tended to find the format more acceptable.

Key Trends

- Survey results suggest that participation in the VC has benefited front-line staff by increasing knowledge about PACT, access to PACT-related resources, and peer-to-peer exchange of ideas. However, these benefits were not equally distributed, and several opportunities for greater impact remain. *(Read more)*
- The potential benefits of the VC are hampered by challenges related to time and staffing that mirror barriers reported to impede PACT implementation on a broader scale. Although it is beyond the scope of the VC alone to solve these challenges, acknowledging and addressing these constraints in the context of the VC may mitigate their impact and facilitate movement toward their resolution. *(Read more)*
- Perceived lack of leadership support at certain facilities poses an unaddressed barrier to achieving and sustaining teams' engagement and optimism about PACT. *(Read more)*

Opportunities for Improvement

- ❖ Prompt presenters to craft presentations that speak to the needs of key target groups (e.g., clinical and clerical support staff; CBOC teams; "atypically" staffed teams) and that address the challenges of implementing recommended practices in the context of persistent resource constraints.
- ❖ Offer newer PACTs (particularly those at CBOCs) additional support around team-building and basic team processes (e.g., via more intensive coaching, more opportunities for contact with experienced teams).
- ❖ Ensure that ALL team members have truly protected time to participate in practice improvement work; continue to emphasize the importance of maintaining such protected time at all organizational levels.
- ❖ Equip coaches with resources to help teams problem-solve around ways to adapt PACT principles and strategies to local circumstances, and to engage more passive or resistant team members. Facilitate contact between coaches at different facilities to encourage information sharing and collective problem-solving.
- ❖ Teams at some sites may need support from outside the facility to address larger systemic issues. Leaders at certain sites may benefit from targeted education about PACT concepts and processes in order to ensure that teams have the resources (staff, time) and autonomy needed to realize the goals of PACT.

The VISN 4 Virtual Learning Collaborative was launched by Dr. David Macpherson, Chief Medical Officer for VISN 4, in January 2012 as a central part of the VISN's plan to advance PACT implementation and spread. It aims to address needs not met by earlier training and spread initiatives (i.e., Regional PACT Collaboratives and PACT Learning Centers) while at the same time testing an innovative method for encouraging and sustaining organizational change.

It is important to note that the VC model as it was originally conceived assumed that teams would enter the VC with at least some foundational knowledge of PACT, acquired through a 3-day Learning Center training coordinated by the Regional Center of Excellence. However, these introductory trainings were suspended shortly before the VC was to launch. To compensate for this unforeseen turn of events, the VC model was revised so as to have all teams join at the same time, regardless of prior training exposure.

In partnership with the Virtual Collaborative (VC) Planning Committee, the Center for Evaluation of Patient Aligned Care Teams (CEPACT) developed The Survey of Learner Experiences as part of a larger multi-method evaluation of the VC. The overall goals of this evaluation are to capture and assess (a) the evolution of the VC model during the first 9 months of its implementation, and (b) the experiences and perceptions of VC participants.

The Survey of Learner Experiences was fielded twice, once at mid-point (April 2012) and again at the 9-month mark (September 2012). The present report focuses on results[3] and findings from Round 2 of the survey, reflects on trends over the first year of the VC, and presents opportunities for improving learner experiences in the future.

Key components of the Virtual Collaborative model

- **Live Meeting sessions**: VISN-wide didactic sessions conducted via Live Meeting twice a month from noon-1:00pm on Thursdays
- **Team meetings**: Dedicated time for teams to meet outside of the Live Meeting sessions to work on PACT implementation
- **Homework**: Assignments for teams to complete between Live Meeting sessions, designed to promote hands-on application of Live Meeting content
- **Additional resources** and supports for teams, including on-site coaches and a central SharePoint site maintained by the VC coordinator that draws together VC- and PACT-related resources from various sources and also houses recordings of all Live Meeting sessions.

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[3] Section VII lists selected tables only; readers may request additional tables by e-mailing Anneliese.Butler@va.gov.

Survey design and methods are summarized in our Midpoint Report.[4] Details specific to the approach taken for Round 2 are highlighted below.

Data Collection and Analysis

As in Round 1, the second survey was announced and endorsed by Dr. Macpherson during the 9/20/12 Live Meeting session, and an email invitation containing a Web Link to the survey was sent to all registered VC participants immediately following this session. Survey responses were collected anonymously in order to ensure VA staff would feel comfortable in giving honest feedback. A limitation of collecting survey data anonymously is that we do not know the extent to which there was an overlap between respondents to Rounds 1 and 2. For this reason, we must treat these two respondent groups as independent samples.

Modification: The survey period for Round 2 was extended from two to five weeks in order to offset the effects of survey fatigue generated by the volume of surveys directed at PACT teams (especially providers) over the summer.

As before, residents and those with no involvement in the VC to date were excluded from analysis. Survey responses were dichotomized (e.g., agree and strongly agree versus other) and all comparisons were made using Chi square tests. Multiple comparisons (i.e., between different roles) were done using Bonferroni adjustment. Responses to open-ended survey items were reviewed and summarized using ATLAS.ti to identify positive feedback as well as opportunities for improvement (at the local and VISN level) from the perspective of VC participants.

Survey Aims

1. To determine the ***extent of participation*** in VC activities, including Live Meeting sessions, team meetings for planning, and homework assignments.
   1.a. To identify differences in extent of participation by role, site, facility type, and prior exposure to PACT trainings (i.e., NE PACT Learning Collaborative, Center of Excellence/Learning Center training).

2. To assess learners' perspectives on the ***usefulness*** and ***value*** of each VC activity/component (including Resources) and of the VC as a whole.
   2.a. To identify differences in perceived usefulness/value by role, site, facility type, and prior exposure to PACT trainings.

3. To gauge learners' perceptions of the overall ***impact*** of the VC (as a whole), in terms of increasing PACT-related knowledge and access to resources.
   3.a. To identify differences in perceived impact by role, site, facility type, prior exposure to PACT trainings, and extent of participation in VC.

4. To assess the ***acceptability of the VC format*** relative to prior PACT training initiatives, which were off-site and more concentrated/time-intensive.
   4.a. To identify differences in perceived acceptability of the VC format by role, site, facility type, prior exposure to PACT trainings, and extent of participation in VC.

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[4] A copy of the Midpoint Report is available upon request and can also be accessed on the VC SharePoint site.

Please follow hyperlinks to see relevant Tables for each section.

Survey Sample ([Table](#))

Of the 820 participants invited to complete the second survey, we received 371 responses. Of these, 18 were disqualified (17 who reported having no involvement with the VC to date, and 1 who self-identified as a resident). The total remaining sample size for Round 2 was 353 for a response rate of 43%, slightly higher than the response rate for Round 1 (41%, n=335).

Those who answered the second round were similar to those who answered the first round with respect to role, primary site, whether or not they had prior PACT training and if they attended 5-7 sessions. In both survey rounds, Primary Care Providers (PCPs) were most strongly represented (34% and 39% for Rounds 1 and 2, respectively), followed by RN Care Managers (28% and 25%), Clinical Associates (18% and 17%), and Clerical Associates (7% and 5%). About one-half of respondents in each survey were located at a VA Medical Center (VAMC), and about one-third had attended some form of prior PACT training. VAMC respondents were considerably more likely than their CBOC peers to have attended PACT training prior to entering the VC (50% vs. 29%, p=0.0002).

Aim 1: Extent of Participation in Virtual Collaborative Activities ([Tables](#))

Participation in Live Meeting Sessions
Three hundred twenty-eight (328) respondents (93% of the sample) reported that they had attended 1 or more of the 7 Live Meeting sessions that took place between April and September 2012. Of these, 116 (35%) said they attended with other members of their team, and 130 (40%) said they attended with a group of teams. A higher proportion relative to Round 1 reported attending the Live Meeting sessions on their own (23% vs. 9%).

A majority of respondents (57%) attended 5 to 7 sessions during this period, nearly the same proportion as for Round 1 (61%). RNs in this sample were significantly less likely to attend most/all the Live Meeting sessions than PCPs (45% vs. 71%, p=0.00).

Participation in Team Meetings
Just under half (49%) of respondents in Round 2 reported that they met with their teams at least every two weeks in the period from April to September 2012. Respondents at VAMCs were more likely than those at CBOCs to report meeting every 2 weeks or more (55% vs. 44%,

> **Aim 1 Summary: Participation in VC Activities**
> - Participation in Live Meeting sessions was comparable to participation at midpoint, with a majority of respondents reporting that they had attended all or most Live Meeting sessions. Respondents in Round 2 were also more likely to have attended sessions alone rather than with others compared with respondents to Round 1.
> - Participation did not vary significantly by facility type or exposure to prior PACT training; however, RNs were less likely than PCPs to have attended most sessions.
> - Compared to Round 1, respondents in Round 2 were less likely to report that their teams had been meeting at the expected frequency. Exposure to prior PACT training and working at a VAMC were associated with higher team meeting frequency.
> - Similar to Round 1, most respondents indicated that team meetings were shorter than originally envisioned.
> *(continued on next page)*

p=0.05), as were those who had participated in previous PACT training compared to those with no prior training (60% vs. 42%, p=0.00). Compared to respondents in Round 1 of the survey, Round 2 respondents were less likely to have met every 2 weeks or more (49% vs. 63%, p=0.00).

As in Round 1, comparatively few respondents (15%) reported that their teams met for 60 minutes or more, and this did not vary by facility type or participation in prior PACT training.

Participation in Homework

Homework has been a less prominent feature of the VC since June 2012, with only 3 assignments occurring after the mid-point mark (in late-April, May, and June). Results to survey items regarding VC homework should be interpreted with this in mind.

About one-third of respondents (31%) said their team completed all homework assignments, and slightly less than one-half (47%) said their team completed most or some assignments. Of those who completed any homework, a slight majority (54%) said that it was a team activity. Compared to Round 1 respondents, Round 2 respondents were less likely to have completed all homework assigned during the corresponding period (31% vs. 51%, p=0.00).

> **Aim 1 Summary: Participation in VC Activities** *(continued)*
> - Respondents in Round 2 were less likely to have completed all homework assignments compared with Round 1 respondents. About one-third of respondents said their team had completed all assignments since the midway point, while almost half completed some or most of the assignments. Approximately half said that homework was completed as a team.
> - One-fifth of respondents were considered to have participated fully in the VC between April and September; those at a VAMC and those with prior PACT training were more likely than those at a CBOC or those with no prior training to be getting the full VC experience.

Overall Engagement

As in Round 1, we used two measures to summarize overall engagement in the VC. The first of these was a "meeting dose" variable based on frequency and duration of team meetings. Teams who spent more time together (met frequently and for longer durations) were said to have a "high dose," and those who met less frequently and for shorter durations were said to have either a "medium" or a "low dose." Of the 268 respondents who had responses for the contributing variables, 84 (31%) were in the high dose group, nearly the same proportion of respondents as in Round 1 (34%). Respondents from VAMCs were more likely to have a high dose than those from CBOCs (40% vs. 21%, p=0.00).

Another measure of overall engagement was a dichotomous variable that took into account whether or not the respondent could be considered to have had the "full VC experience," defined as having attended at least 4 Live Meeting sessions between April and September 2012 and having a high team meeting dose.[5] According to these specifications, 70 respondents (20%) were considered to have had the full VC experience. Respondents who did not meet the criteria or who failed to answer any of the contributing questions were not considered to have had the full VC experience. Respondents from VAMCs were more likely to have had the full VC experience than those from CBOCs (30% vs. 13%, p=0.00), as were those who had participated in prior PACT training (29% vs. 15%, p=0.00).

Aim 2: Perceived Usefulness and Value of the Virtual Collaborative (Tables)

Usefulness of Live Meeting Sessions

Over half of respondents (54%) agreed that the presentations made during Live Meeting sessions were useful, and nearly two-thirds (61%) found the stories and examples from other teams to be useful. Just under half of respondents endorsed the polls (49%) and felt that the Live Meeting sessions were a good use of their time (45%). Round 2 responses did not differ significantly from Round 1 responses for these items.

Comparisons by role revealed that RN Care Managers were significantly more likely than either Clinical Associates (70% vs. 50%, p=0.05) or PCPs (70% vs. 47%, p=0.00) to find Live Meeting presentations useful. RNs were also more likely than PCPs to say that team stories/examples were useful (75% vs. 53%, p=0.01). Comparisons by facility type revealed no significant differences between VAMC and CBOC respondents for these items. By contrast, those respondents who had prior PACT training, spent more time with their team ("high

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[5] We revised the original definition of the "full experience" variable used in Round 1 analyses in order to reflect the ways in which the VC evolved over time (i.e., homework was less central to the VC experience). Thus, while the "full experience" variable included items pertaining to homework completion for Round 1, those items were omitted for Round 2.

dose"), and/or got the full VC experience were significantly more likely to perceive Live Meeting presentations and team stories as useful and to feel that the sessions were worth their time.

Usefulness of Team Meetings

As in Round 1, a majority of respondents (58%) agreed that team meetings helped with PACT implementation. We found no significant differences by role; however, respondents stationed at a VAMC were more likely than those at CBOCs to agree with this statement (65% vs. 50%, p=0.02). More striking differences were found for those with prior PACT training compared to those without (71% vs. 48%, p=0.00), those with a high team meeting "dose" (85% vs. 46%, p=0.00), and those getting the full VC experience (89% vs. 47%, p=0.00).

Similarly, most respondents (60%) felt that team meetings were a good use of time. Again, there was significantly stronger agreement among respondents stationed at a VAMC (66% vs. 52%, p=0.02), those with prior PACT training (74% vs. 49%, p=0.00), those with a high team meeting "dose" (85% vs. 48%, p=0.00), and those who participated fully in the VC (87% vs. 50%, p=0.00).

> **Aim 2 Summary: Perceived Usefulness**
> - Over half of survey respondents found the Live Meeting sessions to be of use, especially the stories and examples from other teams. RN Care Managers were more likely to find the sessions useful, as were those who had prior PACT training and those who were highly engaged in the VC.
> - A majority of respondents agreed that team meetings were useful. Team meetings were valued more highly by respondents who were stationed at a VAMC, had prior PACT training, and/or were fully engaged in the VC.
> - As in Round 1, homework was the least popular aspect of the VC; respondents who were fully engaged in the VC were more likely to agree that the assignments were useful in making PACT related changes
> - Of those respondents who used available resources (coaches, SharePoint, VC coordinator), those participating fully in VC activities were also more likely to rate these resources as useful.

Usefulness of Homework

Less than one-quarter (22%) of respondents in Round 2 agreed that the VC homework assignments had helped with PACT implementation, and they were less likely to agree with this statement than Round 1 respondents (22% vs. 30%, p=0.05). Only about one-fifth (19%) of Round 2 respondents agreed that the homework was a good use of their time.

Responses to both homework-related items differed significantly by measures of overall engagement: of respondents with a high team meeting "dose" and those who were getting the full VC experience, just over one-third agreed that the homework had helped with PACT implementation (38% and 37%, respectively), and nearly one-third agreed that the homework assignments were a good use of their time (32% and 30%, respectively); by contrast, rates of agreement were roughly half as high for respondents who did not meet these criteria (see details).

Usefulness of VC Resources

Of those using available resources (coaches, SharePoint, VC Coordinator), just under half of respondents felt that the resources were useful, roughly the same proportion as in Round 1. RNs found the SharePoint site more useful than PCPs did (62% vs. 37%, p=0.01). Respondents with previous PACT training were significantly more likely to endorse the usefulness of both the SharePoint site (55% vs. 43%, p=0.05) and the VC Coordinator (62% vs. 36%, p=0.00), compared to those without such training. As with all other VC components, the highly engaged group (full experience) was more likely to perceive all VC resources as useful compared with those who were less engaged.

Aim 3: Perceived Impact of the Virtual Collaborative (Tables)

A number of survey items assessed participants' views about the VC's impact, including its impact on their knowledge about PACT, on the general awareness of PACT at their facility, on the degree of communication with other PACT teams, on their access to resources and experts who could answer questions about PACT, as well as

whether they felt that participating in the VC had value for someone in their role and was helping their PACT move forward with implementation.

A majority of respondents agreed or strongly agreed that the VC increased their knowledge of PACT and the general awareness of PACT at their facility (64% and 52%, respectively), and that it had improved access to PACT experts and other PACT-related resources (50% and 58%, respectively). Somewhat fewer respondents agreed that participation in the VC had increased their communication with other primary care teams (44%), was worthwhile for someone in their role (47%), or was helping their team put PACT concepts into action (40%). Round 2 responses did not differ significantly from those obtained in Round 1.

> **Aim 3 Summary: Perceived Impact**
> - A majority of survey respondents agreed that participation in the VC has positively impacted their knowledge about, awareness of, and access to further resources related to PACT.
> - Close to one-half of respondents felt that participation in the VC was worthwhile for someone in their role; a plurality agreed that the VC had increased communication with other teams and helped their team progress with PACT implementation.
> - Respondents with prior PACT training and those who were highly engaged in the VC were considerably more likely to perceive a positive impact.

Both RN Care Managers and Clinical Associates were significantly more likely than PCPs to agree that participation in the VC had increased their access to people who could answer PACT-related questions (59% vs. 40%, p=0.03, and 61% vs. 40%, p=0.04, respectively).

Those with prior PACT training were significantly more likely to agree that participating in the VC had increased communication with other teams (54% vs. 37%, p=0.00), access to experts (61% vs. 43%, p=0.00), and access to PACT-related resources (70% vs. 50%, p=0.00). They were also more likely to agree that VC participation was worthwhile for someone in their role (58% vs. 40%, p=0.00), and that it was helping their team to put PACT concepts into action (50% vs. 33%, p=0.00).

Respondents who met criteria for high overall engagement (high team meeting dose, full VC experience) consistently voiced stronger agreement with items assessing the VC's impact. Differences were substantial and significant across all of these items (see details), but the differences in perceived impact on PACT implementation were most striking: approximately two-thirds of those in the highly engaged group agreed that participating in the VC was helping their team to implement PACT, compared to only one-third of all remaining respondents.

Aim 4: Acceptability of the Virtual Collaborative Format (Tables)

Respondents were asked to assess the acceptability of the VC in comparison to a more traditional, off-site training format, in terms of the level of training received and the acceptability of integrating training sessions into the regular work day.

Over half of all respondents felt the VC format was an acceptable alternative to off-site training and said they liked that the VC provides PACT training in "small doses" over several months (54% and 53%, respectively). Forty-two percent agreed that they were getting the same training through the VC as they would from an off-site training, and they were more likely to agree with this than respondents in Round 1 (42% vs. 33%, p=0.03). About one-third (35%) agreed that participating in the VC had not interfered with their day-to-day work, while 42% disagreed with this statement.

> **Aim 4 Summary: Acceptability**
> - Over half of respondents felt the VC format was an acceptable alternative to off-site training and liked receiving training in "small doses" spread over time. Respondents to this survey were more likely than Round 1 respondents to feel that the VC offered a comparable level of training to an off-site format. However, 42% indicated that participation in the VC interfered with their day-to-day work.
> - Respondents with prior PACT training and those who were highly engaged in the VC also tended to find the format more acceptable.

Those with previous PACT training were more likely than those without to agree that the VC offered the same level of training as an off-site training would (49% vs. 37%, p=0.04), and that participating in the VC had not interfered with their work (42% vs. 30%, p=0.04). They were also more enthusiastic about getting training in "small doses" (61% vs. 48%, p=0.03). Respondents who spent more time meeting with their teams were also more apt to agree that the VC offered equivalent training (57% vs. 37%, p=0.00) and that their participation had not interfered with their day-to-day work (48% vs. 30%, p=0.00). Similarly, those who met criteria for high engagement in the VC showed significantly higher agreement on all measures of acceptability (see details).

After noting the limitations of the study, we highlight and expand upon key trends that emerged from our analyses of rounds 1 and 2 of the Survey of Learner Experiences by drawing on qualitative data gathered since the VC was launched (i.e., write-in responses to open-ended survey items, interviews with key contacts at each facility). We conclude with some reflections on opportunities for improving learner experiences in the months ahead.

Limitations

Certain limitations must be kept in mind when reading and interpreting the results reported here:

- Our survey methods do not permit us to generalize results, as we do not know whether the learner experiences of survey respondents are representative of all VC participants.

- The survey design assumes that all participants are members of defined and fully activated PACTs; however, we know from survey comments and interviews with key contacts that some PACT teams are not yet truly functioning as such due to several interrelated barriers around staffing, workload, and time constraints. Furthermore, the VC registration list included some individuals who were not in a core team role (e.g., managers or supervisors). Because the wording of several survey items assumes membership on an active PACT team, it is possible that some respondents dropped out before completing the survey, or else selected the best available response option, even if it did not capture their experience accurately.

- In addition, the inclusion of a "neutral" response category on most survey items limits what can be learned from this survey, because for several survey items, a sizeable proportion of respondents chose to remain neutral and it is impossible to know whether rates of agreement would have increased or decreased had respondents been "forced" to choose.

Key Trends

I. *Survey results suggest that participation in the VC has benefited front-line staff by increasing knowledge about PACT, access to PACT-related resources, and peer-to-peer exchange of ideas ([see quotes](#)). However, these benefits were not equally distributed, and opportunities remain for improving the VC's impact on teams' capacity to make PACT-related changes.*

> *"[Some VC sessions] were helpful. It seems like the majority of them were more directed towards the provider and not the rest of the PACT team." (Clinical Associate, VAMC)*
>
> *"I think having a training on PACT, to get a basic understanding prior to the VC, would have been very helpful. All these months into it, we are just now finding out about tools to help with this process. I feel that we are embarking on a quest without having the basic fundamentals in place first." (Clinical Assoc, CBOC)*
>
> *"I am not yet fully PACT as we are quite low in RNs… The presenters of the collaborative could give alternative ways of doing things for teams like ours that have 1 RN for 8 providers….instead of making suggestions for the ideal theoretical team that we currently don't have yet." (PCP, CBOC)*   *([See more quotes](#))*

Across both surveys, the VC appears to have been most useful to those participants who had prior PACT training and those who were able to fully participate in VC activities. In addition, participants at VAMCs were considerably more likely to have had prior PACT training and to be fully engaged in VC activities than were those at CBOCs, indicating that VAMC participants have had more overall exposure to PACT training of any kind. Further, RNs report receiving greater benefit from the VC compared with other team members.

Together, these results suggest that the VC has been less successful at engaging certain subgroups of learners most in need of greater inclusion and training in PACT, namely primary care staff at CBOCs, newly formed PACTs, and support staff. While available data do not provide a definitive explanation for this finding, they do point to a number of possible explanatory factors:

- Those with greater overall exposure to PACT training are in many ways better positioned to perceive a benefit from the VC because they are starting from a comparatively stronger base: they are familiar with the basic concepts and have a scaffold on which to build; they and their team members likely have more experiential (as opposed to purely conceptual) knowledge of PACT; and they may feel greater motivation and perceived capacity to attempt PACT-related changes by virtue of their longer immersion in "PACT culture."

- It is not surprising that those who lacked prior training derived less benefit from the VC when one considers the circumstances under which the VC was launched. As noted earlier, the VC model as it was originally conceived assumed that learners entering the VC would have at least some foundational knowledge of PACT. When the Center of Excellence trainings were suspended shortly before the VC launch date, organizers had to decide whether to start all teams at the same time despite differences in basic knowledge, or to proceed as planned. They opted for greater inclusion but had little time to adjust the model to compensate for this unexpected change in circumstances. This may account for at least some of the difference in perceived benefit between participants with versus those without prior training.

- Teams at CBOCs may experience greater tension between clinic demands and expectations for VC participation, as they often have less back-up and are thus more vulnerable to staff absences. Many CBOC teams also have less frequent and intensive contact with local coaches and other PACT experts due to their geographic distance from a VAMC.

- Whether at CBOCs or VAMCs, teams at an earlier stage of team development (i.e., recently formed PACTs) are at a disadvantage compared to more mature PACTs, in that they must learn what it means to operate as a PACT even as they are asked to engage in practice improvement work as if they were seasoned PACTs.

- A number of participants commented that the content of the VC was not relevant to their needs. Clerical and clinical associates in particular voiced a wish for more content specific to their role functions under PACT, and newer teams may need more content on team-building than has been offered so far.

- In terms of both content and timing, the VC has been shaped to meet the needs of providers; however, less attention has been given to other team members, especially clerical associates, who remain the least involved group.

II. *The potential benefits of the VC are hampered by challenges related to time and staffing that mirror barriers reported to impede PACT implementation on a broader scale. Acknowledging and addressing these constraints in the context of the VC may improve learner engagement and motivation for change.*

> *"…Only my RN comes to the collaborative, no one else from my team (LPN, clerical staff) has time or has been released from work tasks. I think if we value something then we make it a priority so if the PACT is truly a priority, set aside time away from work to let people attend." (PCP, VAMC)*
>
> *"…many people are filling multiple roles [on] PACT teams [and] in other areas of the clinic as well. PACT is a good concept in theory- however it cannot be implemented to its full potential if we are not given the time and resources to do it. We no longer have the time for team huddles; team meetings due to short staffing" (RN, CBOC)*
>
> *"We are so severely understaffed that going to these sessions is like sending a diabetic to lunch at a candy store. What's the use when you can't avail yourself of such wonderful 'theoretical' concepts. PACT is flying overhead and we're still in the bunkers." (PCP, VAMC)*
>
> *"…not enough people work at my CBOC to form a PACT. There is no team. So, since there is no team and no PACT at my CBOC, having to participate in the Virtual collaborative is like teaching a computer course to someone without a computer. Worthless." (PCP, CBOC)* (See more quotes)

Dr. Macpherson has estimated that teams need a minimum of one hour a week set aside to dedicate to practice improvement work. Round 2 results underscored the ongoing challenge of creating and preserving time for team-based practice improvement work in the face of competing priorities and the need for teams and facilities as a whole to adapt to ongoing resource constraints (e.g., staff absences, loss of staff, increased panel sizes).

Protected time is still not universally available, and where it is, there are signs of erosion:

- The percentage of respondents who reported that their teams met at least every two weeks was significantly lower in Round 2 than in Round 1. While we cannot infer from this that team meeting frequency has decreased overall, since we assume the two groups are independent, qualitative data lend support to this possibility.
- Protected time is not equally available to all team members. Qualitative data suggests that, as with content and timing, local VC implementation has prioritized the needs of providers, rather than those of the entire team. In some cases, there is an expectation that all team members will participate but clinic schedules have not been restructured in such a way to make this consistently feasible. In other cases, support staff are no longer expected to participate in any regular way.

In addition to issues of time, challenges related to staffing levels persist:

- Fluctuations in available staff on any given day hamper VC participation, as clinic demands and patient care will always take priority over training activities. While this is true for all teams, regardless of staffing levels, clinics with fewer available staff to help cover for absent team members are particularly hard hit.
- Many survey respondents and key contacts described team configurations that do not correspond to the ideal team model at the heart of PACT (i.e., 1 PCP, 1 RN, 1 LPN, 1 clerk), and which is the sole model reflected in all PACT training materials. While pilot teams either were built or were already staffed in accordance with this official model, more recently formed PACTs are often configured according to some "hybrid" model or lack key roles on the team. Write in responses indicate that many frontline staff do not feel that the VC "speaks to" the particular realities and needs of their team, and many conclude that they cannot implement PACT until their team matches the ideal model. While this may be a misperception in some cases, in certain cases there is a real need for additional staff in order for PACT to move forward. It may be worth looking more closely at how thinly spread people are, to ensure that expectations set for teams are realistic.

III. *Perceived lack of leadership support at certain facilities poses an unaddressed barrier to achieving and sustaining teams' engagement and optimism about PACT.*

"I am not sure that our ACOS fully supports PACT; trusts us; wants to empower patients; values the effort I put into building relationships with my patients." (PCP, VAMC)

"The PACT concept is good but our suggestions are not taken. Management wants to 'get the numbers up' and have threatened the providers with being fired." (Clinical Associate, VAMC)

"[Changes at the team level are hampered by] administrative red tape … [Let] us make changes on the lowest level - everything does not need to come from the top down - if we had some independence to arrange our scheduling, I think there would be less overtime, more quality care delivered and more employee satisfaction." (PCP, CBOC)

"[The VC] means nothing [because] things you talk about are NEVER implemented at [our] facility. … going to the collaborative is torture … I go learn about things other facilities try and do [that] we aren't allowed [to do] … I get to hear things that the National and VISN recommend but they are ignored at this facility … I am looking for someone above me to finally care and listen to what I am saying. … Don't just go to the senior management here … Come see the people that try to implement PACT [and] hear the truth." (PCP, VAMC) *([See more quotes](#))*

Open-ended survey responses convey considerable frustration from staff at facilities where there is a perceived lack of support and engagement by executive leadership. Many comments express varying degrees of skepticism regarding local leaders' understanding of and commitment to PACT:

- Some respondents are doubtful about leadership's investment in PACT in comparison with other competing priorities.
- Others feel that the PACT Compass metrics are poor indicators of meaningful change and are subject both to misinterpretation and manipulation by executive leadership. A number of survey respondents and key informants spoke of a discrepancy between performance on the Compass measures and the actual situation on the ground; a few believed that local leadership was not only aware of this discrepancy but was also exploiting it to create the impression of compliance without actually supporting needed changes.
- In addition, frontline staff at certain sites reportedly have little or no input into planning and decisions around PACT. Survey and interview data describe situations marked by excessive "administrative red tape" and a lack of autonomy at the team level.
- Finally, we have heard isolated reports of teams who feel they are being "punished" for high performance by having vital resources withdrawn. For example, one high-functioning multi-provider team that lost a PCP was informed that the PCP would not be replaced since the team had been doing so well.

Opportunities for Improvement

Several opportunities exist to enhance the VC experience for those who have benefited less to date. In particular:

- Presenters could be explicitly prompted to consider the particular needs of key target groups when developing their presentations. Survey results suggest that the role functions of clinical and clerical associates as well as CBOC-specific circumstances and implementation challenges deserve special attention.
- Newer PACTs, particularly those at CBOCs, could benefit from additional support around team-building and basic team processes, for instance through more intensive coaching and greater opportunities for contact with more seasoned teams.
- Homework, while unpopular, can be a useful catalyst for change provided that it is truly a team activity. As the VC moves into its next phase of more team-driven practice improvement work, coaches should assess not only *whether* but also *how and by whom* assignments are completed.

The changes needed to fully resolve persisting barriers around time and staffing are beyond the VC's sphere of influence. Nevertheless, there are ways in which the VC might mitigate the impact of these challenges and facilitate movement toward their resolution:

- ALL team members need protected time to attend VC sessions and participate in team meetings, especially those without dedicated administrative time. Without such protected time, it will be hard for them to engage in, feel engaged by, and move forward with practice improvement work, and the VC may inadvertently contribute to staff burnout. The importance of maintaining protected time should be re-emphasized frequently, at all organizational levels.
- Future VC content should reflect and speak to the actual conditions in which teams are working, including the reality of persistent resource constraints and sites' adaptations to those (e.g., alternate staffing models).
- Coaches should be equipped with resources and tools to help teams (including those that are not yet structured or operating as PACTs) problem-solve around ways to adapt PACT principles and strategies to their specific local conditions. Coaches may also need tools to engage more passive or resistant team members, and to help teams through their "growing pains." VC organizers could support coaches (and ultimately teams) by facilitating some form of structured virtual forum (e.g., a monthly telephone meeting, an online forum), which would help coaches network, share information and ideas, engage in collective problem-solving, and ask questions of PACT experts around the VISN.
- Teams at some sites may need support from outside the facility to address larger systemic issues. Intercession at the executive leadership level might be warranted in cases where local facility leadership appears to be working at cross-purposes to PACT (e.g., reducing staff on high-performing teams, scrutinizing

open slots on clinic schedules, inhibiting team-level autonomy to innovate). Leaders at certain sites may benefit from targeted education about PACT concepts and processes in order to ensure that teams have the resources (staff, time) and autonomy needed to realize the goals of PACT.

- ❖ In some cases, there may be a real need for additional staff in order for PACT to move forward. It may be worth looking more closely at how thinly spread people are, to ensure that expectations set for teams are realistic.

Survey Sample ([Return to text](#))

Table 1. Characteristics of study sample

Response Rate

Surveys sent	820	
Responses	371	
Disqualified	18	
Total Valid Responses	353	
Survey Response Rate	43%	

Respondent characteristics (n=353)   (% of total)*

Role:

PCPs	136	(39%)
RN/Care Managers	87	(25%)
Clinical Associates	61	(17%)
Clerical Associates	17	(5%)

Facility type:

Primary Site is VAMC	168	(48%)
Primary Site is CBOC	142	(40%)

Training exposure

Had prior PACT training	125	(35%)
Attended 5-7 Live Meeting sessions (since April 2012)	191	(54%)

Parent facility:

Altoona	22	(6%)
Butler	24	(7%)
Clarksburg	23	(7%)
Coatesville	11	(3%)
Erie	28	(8%)
Lebanon	51	(14%)
Philadelphia	56	(16%)
Pittsburgh	33	(9%)
Wilkes-Barre	34	(10%)
Wilmington	28	(8%)

* Percentages may not total 100%, as some respondents chose not to answer these items.

Extent of Participation ([Return to text](#))

Table 2.1. Mode of Live Meeting participation

Attended at least one Live Meeting session	328	(93%)
Attended with other team members	116	(35%)
Attended with other teams	130	(40%)
Attended on own	75	(23%)

Table 2.2. Participation in VC activities

Attended 5-7 sessions	191 (57%)
Met every 2 weeks or more	158 (49%)
Met for 60 min or more	39 (15%)
Did all homework	98 (31%)
HW done as team	128 (54%)
High Dose	84 (31%)
Full Experience[6]	70 (20%)

Table 2.2.1. Comparisons by VAMC vs. CBOC

	VAMC	CBOC	p-value
Attended 5-7 sessions	56%	62%	0.28
Met every 2 weeks or more	55%	44%	0.05
Met for 60 min or more	16%	12%	0.32
Did all homework	27%	35%	0.18
HW done as team	54%	53%	0.94
High Dose	40%	21%	0.00
Full Experience	30%	13%	0.00

Table 2.2.2. Comparisons by Role

	Clerical Associate	Clinical Associate	RN/ Care Manager	PCP	p-value
Attended 5-7 sessions	41%	59%	45%	71%	0.00
Met every 2 weeks or more	53%	54%	52%	45%	0.59
Met for 60 min or more	15%	26%	8%	13%	0.04
Did all homework	35%	36%	33%	26%	0.49
HW done as team	45%	61%	59%	47%	0.27
High Dose	38%	38%	31%	27%	0.54
Full Experience	18%	31%	21%	19%	0.27

Table 2.2.3. Comparisons by prior PACT training

	Prior training	No Prior training	p-value
Attended 5-7 sessions	56%	58%	0.77
Met every 2 weeks or more	60%	42%	0.00
Met for 60 min or more	15%	14%	0.73
Did all homework	32%	30%	0.65
HW done as team	57%	51%	0.40
High Dose	36%	28%	0.16
Full Experience	29%	15%	0.00

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[6] "Full experience" defined as attending ≥4 sessions and having a high team meeting "dose."

Usefulness and Value of VC ([Return to text](#))

Table 3. Usefulness (% who agree or strongly agree)

Live meetings are a good use of time	144 (45%)
LM presentations useful	175 (54%)
LM stories and examples useful	195 (61%)
LM polls useful	156 (49%)
Team meetings help with PACT implementation	156 (58%)
Team meetings a good use of time	160 (60%)
HW helps with PACT implementation	55 (22%)
HW a good use of time	46 (19%)
Coaches are useful resource	113 (47%)
SharePoint is useful resource	125 (48%)
VC Coordinator is useful resource	114 (47%)

Table 3.1. Usefulness by VAMC vs. CBOC (% who agree or strongly agree)

	VAMC	CBOC	p-value
Live meetings are a good use of time	47%	41%	0.27
LM presentations useful	58%	49%	0.11
LM stories and examples useful	61%	61%	0.99
LM polls useful	49%	48%	0.88
Team meetings help with PACT implementation	65%	50%	0.02
Team meetings a good use of time	66%	52%	0.02
HW helps with PACT implementation	20%	25%	0.40
HW a good use of time	17%	21%	0.53
Coaches are useful resource	51%	42%	0.21
SharePoint is useful resource	48%	48%	0.92
VC Coordinator is useful resource	45%	49%	0.49

Table 3.2. Usefulness by Role

	Clerical Associate	Clinical Associate	RN/ Care Manager	PCP	p-value
Live meetings are a good use of time	50%	43%	51%	40%	0.44
LM presentations useful	50%	48%	70%	47%	0.00
LM stories and examples useful	63%	60%	75%	53%	0.02
LM polls useful	56%	45%	60%	44%	0.10
Team meetings help with PACT implementation	38%	58%	64%	58%	0.39
Team meetings a good use of time	54%	58%	64%	60%	0.88
HW helps with PACT implementation	36%	34%	23%	16%	0.06
HW a good use of time	36%	30%	18%	12%	0.03
Coaches are useful resource	64%	54%	55%	38%	0.06
SharePoint is useful resource	54%	49%	62%	37%	0.01
VC Coordinator is useful resource	64%	43%	56%	40%	0.12

Table 3.3. Usefulness by prior PACT training

	Prior training	No Prior training	p-value
Live meetings are a good use of time	55%	39%	0.00
LM presentations useful	65%	48%	0.00
LM stories and examples useful	70%	55%	0.01
LM polls useful	57%	44%	0.03
Team meetings help with PACT implementation	71%	48%	0.00
Team meetings a good use of time	74%	49%	0.00
HW helps with PACT implementation	25%	20%	0.42
HW a good use of time	23%	15%	0.14
Coaches are useful resource	51%	44%	0.23
SharePoint is useful resource	55%	43%	0.05
VC Coordinator is useful resource	62%	36%	0.00

Table 3.4. Usefulness by measures of overall engagement

	High Dose	Low or Med Dose	p-value
Live meetings are a good use of time	60%	41%	0.01
LM presentations useful	73%	50%	0.00
LM stories and examples useful	74%	59%	0.02
LM polls useful	59%	46%	0.06
Team meetings help with PACT implementation	85%	46%	0.00
Team meetings a good use of time	85%	48%	0.00
HW helps with PACT implementation	38%	15%	0.00
HW a good use of time	32%	14%	0.00
Coaches are useful resource	67%	42%	0.00
SharePoint is useful resource	68%	45%	0.00
VC Coordinator is useful resource	63%	48%	0.04
	Full Experience[7]	Not Full Experience	p-value
Live meetings are a good use of time	61%	40%	0.00
LM presentations useful	77%	48%	0.00
LM stories and examples useful	76%	57%	0.00
LM polls useful	60%	45%	0.03
Team meetings help with PACT implementation	89%	47%	0.00
Team meetings a good use of time	87%	50%	0.00
HW helps with PACT implementation	37%	17%	0.00
HW a good use of time	30%	14%	0.01
Coaches are useful resource	66%	40%	0.00
SharePoint is useful resource	65%	43%	0.00
VC Coordinator is useful resource	61%	42%	0.00

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[7] "Full experience" defined as attending ≥4 sessions and having a high team meeting "dose."

Impact of the VC ([Return to text](#))

Table 4. Impact (% who agree or strongly agree)

Increased knowledge of PACT	202 (64%)
Increased awareness of PACT at facility	165 (52%)
Increased communication with other PC teams	138 (44%)
Increased access to people who can answer PACT questions	158 (50%)
Increased access to resources related to PACT	183 (58%)
Think participating in VC is worthwhile for someone in role	148 (47%)
Participating is helping team put PACT concepts into action	126 (40%)

Table 4.1. Impact by VAMC vs. CBOC (% who agree or strongly agree)

	VAMC	CBOC	p-value
Increased knowledge of PACT	65%	62%	0.52
Increased awareness of PACT at facility	51%	54%	0.68
Increased communication with other PC teams	48%	39%	0.15
Increased access to people who can answer PACT questions	53%	46%	0.25
Increased access to resources related to PACT	61%	53%	0.13
Think participating in VC is worthwhile for someone in role	48%	46%	0.76
Participating is helping team put PACT concepts into action	40%	41%	0.95

Table 4.2. Impact by Role

	Clerical Associate	Clinical Associate	RN/ Care Manager	PCP	p-value
Increased knowledge of PACT	76%	61%	67%	62%	0.57
Increased awareness of PACT at facility	65%	57%	56%	46%	0.20
Increased communication with other PC teams	41%	51%	52%	37%	0.10
Increased access to people who can answer PACT questions	47%	61%	59%	40%	0.01
Increased access to resources related to PACT	59%	61%	67%	50%	0.09
Think participating in VC is worthwhile for someone in role	41%	41%	60%	43%	0.05
Participating is helping team put PACT concepts into action	41%	49%	45%	35%	0.21

Table 4.3. Impact by prior PACT training

	Prior training	No Prior training	p-value
Increased knowledge of PACT	66%	63%	0.62
Increased awareness of PACT at facility	58%	49%	0.12
Increased communication with other PC teams	54%	37%	0.00
Increased access to people who can answer PACT questions	61%	43%	0.00
Increased access to resources related to PACT	70%	50%	0.00
Think participating in VC is worthwhile for someone in role	58%	40%	0.00
Participating is helping team put PACT concepts into action	50%	33%	0.00

Table 4.4. Impact by measures of overall engagement

	High Dose	Low or Med Dose	p-value
Increased knowledge of PACT	78%	60%	0.00
Increased awareness of PACT at facility	72%	49%	0.00
Increased communication with other PC teams	61%	41%	0.00
Increased access to people who can answer PACT questions	75%	44%	0.00
Increased access to resources related to PACT	81%	54%	0.00
Think participating in VC is worthwhile for someone in role	60%	45%	0.02
Participating is helping team put PACT concepts into action	66%	32%	0.00
	Full Experience	Not Full Experience	p-value
Increased knowledge of PACT	83%	59%	0.00
Increased awareness of PACT at facility	75%	46%	0.00
Increased communication with other PC teams	64%	38%	0.00
Increased access to people who can answer PACT questions	80%	42%	0.00
Increased access to resources related to PACT	84%	51%	0.00
Think participating in VC is worthwhile for someone in role	64%	42%	0.00
Participating is helping team put PACT concepts into action	70%	32%	0.00

Acceptability of the VC ([Return to text](#))

Table 5. Acceptability (% who agree or strongly agree)

VC format is an acceptable alternative to off-site training	168 (54%)
Feel I am getting the same training through VC as through off-site	131 (42%)
Participation in VC has not interfered with my work	109 (35%)
I like that the VC provides training in small doses	167 (53%)

Table 5.1. Acceptability by VAMC vs. CBOC (% who agree or strongly agree)

	VAMC	CBOC	p-value
VC format is an acceptable alternative to off-site training	53%	54%	0.83
Feel I am getting the same training through VC as through off-site	39%	45%	0.30
Participation in VC has not interfered with my work	35%	35%	0.99
I like that the VC provides training in small doses	54%	54%	0.91

Table 5.2. Acceptability by Role

	Clerical Associate	Clinical Associate	RN/ Care Manager	PCP	p-value
VC format is an acceptable alternative to off-site training	65%	44%	57%	55%	0.31
Feel I am getting the same training through VC as through off-site	47%	36%	47%	43%	0.59
Participation in VC has not interfered with my work	47%	39%	41%	28%	0.11
I like that the VC provides training in small doses	59%	41%	63%	52%	0.06

Table 5.3. Acceptability by prior PACT training

	Prior training	No Prior training	p-value
VC format is an acceptable alternative to off-site training	58%	50%	0.16
Feel I am getting the same training through VC as through off-site	49%	37%	0.04
Participation in VC has not interfered with my work	42%	30%	0.04
I like that the VC provides training in small doses	61%	48%	0.03

Table 5.4. Acceptability by measures of overall engagement

	High Dose	Low or Med Dose	p-value
VC format is an acceptable alternative to off-site training	63%	51%	0.09
Feel I am getting the same training through VC as through off-site	57%	37%	0.00
Participation in VC has not interfered with my work	48%	30%	0.00
I like that the VC provides training in small doses	63%	53%	0.15
	Full Experience	Not Full Experience	p-value
VC format is an acceptable alternative to off-site training	65%	50%	0.03
Feel I am getting the same training through VC as through off-site	61%	36%	0.00
Participation in VC has not interfered with my work	52%	30%	0.00
I like that the VC provides training in small doses	65%	50%	0.02

The following pages list a selection of verbatim quotes from VC participants' write-in responses to open-ended survey questions. These quotes reflect the experiences and perspectives of particular individuals, in particular roles, working under particular circumstances. In listing them here, our intent is to convey the range of learners' experiences, and we caution against generalization. This being said, it is clear that at least some participants at some sites are experiencing significant challenges; regardless of the accuracy of their perceptions, they raise important questions for further exploration and possible intervention.

Praise – What's been useful

Content

"Having an ongoing discussion of VA objectives that sometimes seem meaningless to the front line staff [is useful]. Truly appreciate Dr Macpherson's personal commitment to this." (PCP, VAMC)

"Increased understanding of how individual factors come together to form one big picture" (Clinical Assoc, CBOC)

"getting a more comprehensive operational understanding of PACT principles" (Clinical Assoc, CBOC)

"Definitive accurate up to date information" (Clerical Assoc, CBOC)

"looking at case studies in the [VISN] that's the most helpful, they need to focus on that more" (PCP, CBOC)

"Great concepts. Interesting clinical topics. Innovative, cutting edge, and forward thinking. Thank you for your efforts. Impressive use of new communication and leadership tools." (PCP, VAMC)

"when a specific topic is presented like palliative care, pain management, etc." (RN, VAMC)

"The disease specific ones help to dx, tx, and effectively assist the patients in a patient centric environment" (RN, VAMC)

"Evidence based clinical training, especially the pain/opioids session" (PCP, VAMC)

Perspective

"The information about what other teams are doing (nationally, locally, within the VISN) is good information to know" (PCP, VAMC)

"Knowing that other facilities have the same issues." (PCP, VAMC)

"It gives me the perspective that none of us are having an easy time putting this into practice" (Clinical Assoc, VAMC)

Contact with Peers

"increased communication among team members" (Clinical Assoc, CBOC)

"Getting our teams all together" (Clinical Assoc, CBOC)

"Getting together and sharing information" (Clinical Assoc, CBOC)

"seeing how other team[s] here work together" (Clinical Assoc, CBOC)

"Learning how other teams handle different experiences within PACT." (Clinical Assoc, VAMC)

"I like to see what others are doing so we know other ways to implement and use PACT. It is a very good resource." (Nurse Manager, VAMC)

"It helps to understand how the PACT teams are functioning both at our facility and in VISN in general." (PCP, VAMC)

Format

"several teamlets get training at the same time, rather than one group at a time" (Clinical Assoc, VAMC)

"that many people are receiving information at the same time" (PCP, VAMC)

 "Polls help give great insight into clinical thought processes and how you align with the group" (PCP, VAMC)

 "training in small doses" (PCP, VAMC)

"small steps approach [although it] does feel disconnected at times from what is actually occurring at the local or clinic setting" (PCP, CBOC)

"saves time" (PCP, CBOC)

"reduction of travel makes it much less of a negative impact on group and team productivity" (PCP, VAMC)

"not having to attend off-site conferences [has been useful]; would appreciate continuing VC over off-site training" (Clinical Assoc, VAMC)

Overall

"Revamping how things are done is a good thing. Killing institutional complacency is a good thing. Getting providers and nurses out of their comfort zone in the name of making the product and process better is a good thing. It's like changing coaches on a team. An apt analogy for local Steelers fans is Ben Roethlisberger; he has a new coach, he can't run around and improvise like it's his playground, he's throwing 3-4 touchdowns a game. He was forced out of his comfort zone in order to accomplish something more. I may not always like homework, meetings, and perceived busywork; I greatly appreciate the room for more autonomy with my patients and schedule. Keep it up." (PCP, VAMC)

Constructive criticism

Content   ([Return to text](#))

"[To improve the VC] present info on implementing PACT in CBOCs and the particular challenges in doing this." (RN, CBOC)

 "I got no information as a clerk how to do the daily items. Scheduling PACT calls. Scrubbing schedule concepts." (Clerical Assoc, CBOC)

"I would like for these meetings to describe what we are supposed to be doing in the clinic setting. The only difference our PACT team is doing is scrubbing the schedule and making telephone visits. There is no time to use the TEACH training I received. We are tired of the statistics which do not benefit us." (Clinical Assoc, CBOC)

"All they do is give you statistics which can be manipulated the way you want them. There is no training on how to explain to a patient that he's doing well, a face to face is not needed. To many of these patients it is a 'social time' for them. The only time they get out of the house and the travel pay is quite lucrative." (Clinical Assoc, VAMC)

 "Segment it for different team members to collaborate with each other. Like just for RNs, just for LPNs and have focused sessions. Or have more time included for teams in the same building [to] discuss ideas and changes." (Clinical Assoc, CBOC)

"I would like to see it a little more geared to nursing and front line staff" (Nurse Manager, VAMC)

"It could be useful if we were allowed time for discussions, both within our group (that's connected by one computer), and if we were able to talk with other people. The problem becomes, everyone is at different stages of implementation and have different levels of staffing that it is hard to compare notes outside of the facility." (PCP, VAMC)

"VAs across the country are at different stages. Going over information about Telephone grids and team huddles when our team did not have the grids or time for huddles is not helpful. Education would be better if closer to the time of starting the PACT in our CBOC" (PCP, CBOC)

"always good info, wish I could prioritize it more" (RN, VAMC)

"Having time freed up to actually attend the sessions and for my team to meet at all [would improve my experience]. I have to miss most sessions due to clinical duties, and my team has almost never been able to meet." (PCP, VAMC)

"I think it will be very useful, but we are working very hard to even finish patient notes daily. [I suggest that] on the days there is the collaborative we should have lighter amounts of patients to be seen, so the whole team can be part of the collaborative. We really need more time to be able to finish our daily work." (PCP, VAMC)

"[Having] a one day seminar away from the workplace would be much more productive, useful, and would give everyone a chance to participate…I think the format is not useful or helpful. More than half the time, my clinics have not been cancelled or they have only been partially cancelled so I am eating lunch during the lecture. Only my RN comes to the collaborative, no one else from my team (LPN, clerical staff) has time or has been released from work tasks. I think if we value something then we make it a priority so if the PACT is truly a priority, set aside time away from work to let people attend." (PCP, VAMC)

"At this point, these mandatory meetings have to go away. Teams have received the information, but they do not have time to get together on their own to work on their individual plans." (PCP, VAMC)

"The PACT is being pushed administratively but not being practiced by the majority of the teams because we don't have time, it hasn't been made a serious priority in actuality (in theory it has), team members haven't been able to attend, we are getting the information in a piecemeal fashion that hasn't really taken hold." (PCP, VAMC)

Staffing

"I have been rarely able to participate due to my workload. It is a nice concept." (RN, VAMC)

"I agree with PACT team philosophies and appreciate the Virtual Learning events. However, our site does not have even minimal support staff to implement this program. We had one LPN for 4 providers, and now she has been pulled to manage [another] clinic. We do not have adequate SW, or Behavioral Health support. The PACT concept is good, the implementation and commitment to the underlying structure that is required has been poor." (PCP, CBOC)

"The Virtual Collaborative would be great if all facilities were able to implement it. Unfortunately, resistance from our local leadership to make changes to help us implement PACT has been a MAJOR issue and being extremely short staffed has been another barrier. Unfortunately, we have no LPNs or Health Techs and the RNs do all the triage, phone calls, run all the specialty clinics, do all the dressings, nursing visits, etc. At times, [we have] 2 providers sharing 1 RN with no additional help. This makes it quite difficult to implement any PACT concepts and basically we are NOT doing PACT. It [may] look like it on paper but we are not doing it because of the stated barriers. It would be a great concept otherwise." (PCP, CBOC)

"[Our facility's] PACT model states we should be afforded one RN, one clerical and one clinical per PCP. The clerical and clinical person is the same, meaning their time is split between two separate jobs, but more importantly, there is not enough staff to properly implement PACT. We do not even have the ability to do huddles, which when we began this process, we could and it was very useful. Now our clerical staff are assigned multiple providers a day, and are not able to participate because they are not familiar with the team or patients anymore. … [At this] VA, the PACT model is just a slogan, therefore the VC is not of use." (RN, VAMC)

"Virtual collaborative is fine and I agree with PACT concepts, but we are still not staffed for PACT and this leads to low morale and a significant barrier to achieving PACT metrics. Burnout is increasing due to increased staffing burdens and pressures to perform with inadequate staffing...and I'm not sure the Virtual Collaborative can help with this in the current fiscal/FTE climate." (PCP, VAMC)

"A hybrid concept was introduced to have 1/2 RN per panel. Try doing that for a clinic with 2.4 providers. It doesn't work… The concepts presented were great. The attempt by management to implement the concepts without the agreed upon definition of a PACT team is morale deflating." (RN, CBOC)

"Nothing done in the virtual collaboratives is going to help if we don't have someone enforcing our facility to participate in pact the way they are supposed to. Our facility can make things look good on paper but not in practice; PACT needs to be uniform in the facilities otherwise leadership can make things look like they are happening when it really isn't. PACT has done nothing but increase my work load as a primary care provider." (PCP, VAMC)

"I do like the small steps approach but it does feel disconnected at times from what is actually occurring at the local or clinic setting. [Suggest reducing] the administrative red tape – there are several ways that I think my team could function better but as providers/PACT teams we cannot adjust or rearrange our own schedules, nursing cannot be utilized as case managers because we have no one else to 'room' patients – they cannot provide the care they would like, also pts are not as agreeable as I thought to less visits and more telephone care – they WANT to come in to see us! Let us made changes on the lowest level – everything does not need to come from the top down – if we had some independence to arrange our scheduling, I think there would be less overtime, more quality care delivered and more employee satisfaction. At the team level there are very few changes that can be made to implement PACT to the best of our ability – our hands are tied by the administration!" (PCP, CBOC)

"MANAGEMENT is the MAJOR BARRIER of PACT. They refuse to let anyone work to the top of their license…treat nurses like they are 2nd rate health techs [and] won't allow the teamlet to work together at all!! If we start changing a schedule management comes in and threatens the clerks. Our management has put in a so called supervisor clerk to watch everything the clerks, nurses, and providers do and reports back. Our [pilot] team was [supposed to try] new things [to] figure out how to make things work with the personnel we were given but [is] reprimanded for trying anything. Nursing is really strapped [constrained in what they are permitted to do independently]. I am not asking for anyone to even spend more money at this time I just want someone to allow us to work for the Veteran." (PCP, VAMC)

"Upper management selectively chooses what parts of PACT we will apply and makes dramatic about faces on policy, making it difficult to now from day to day what we are doing. This also effects the patients' ability to understand what is going on… The front line staff feel that PACT is a very effective process, but we have no input into the actual workings here. We do not even have the opportunity to "buy in" to the process before it is changed without warning [and] we do not have adequate staffing to implement the policies and procedures effectively. Managers and supervisors are figurehead with little or no training or experience and so they become mouthpieces for management instead of a conduit of information and data both ways." (Clinical Associate, VAMC)

"I lost a lot of motivation when I found out that my incentive pay was tied to PACT outcomes TWO MONTHS before the end of the evaluation period. It's not that I need incentive pay to be motivated to implement PACT. The basic concepts of patient-centered care make a lot of sense. I like the idea of PACT. But when the higher ups change the work conditions and priorities seemingly at random and without notice or input from those of us 'in the trenches,' I start to wonder if PACT is really a priority for the institution or just some passing management fad. I'm burning out." (PCP, VAMC)

"[Our] institution is resilient to implement any useful PACT changes …stop [the VC and come] to this facility and check directly what was implemented at levels of LPN, RN care coordinator, clinical pharmacist, dietician, social work. Discuss directly with PACT providers and team members and not with service chiefs, which do not practice, and have no clues of pt care and PACT model of care." (PCP, VAMC)

"Getting together and sharing information is good. Except at [this] VA, it appears to be management making PACT look good, even though they don't implement the ideas or listen to suggestions. [This] VA is not implementing PACT in a useful way. It makes things SOUND good, but if anyone would really look in to the details, they would see that [this] VA is moving away from PACT (while still collecting the money to implement it) in MANY ways. … PLEASE, PLEASE send an objective observer to the [VAMC] Primary Care dept and see how far away from PACT we are getting!" (Clinical/Clerical Assoc, CBOC)

Team Communication Exercise (TEX) Executive Summary

Carole Warde MD, Marjorie Pearson PhD

Christina Huang MPH, Lopamurda Das MPH

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INTRODUCTION: Why did we start?

As part of the VA effort to build a stronger national health care system, primary care has been reorganized into a patient-centered medical home model called Patient Aligned Care Teams (PACT). Health professionals and support staff have been regrouped into multidisciplinary units that include a primary care professional (MD or NP), a RN Care Manager, a LVN, and a medical service assistant (MSA). These PACT teamlet members are now required to integrate their work to better deliver excellent care to Veterans, and to continuously improve it. A well-functioning care team is THE essential ingredient in a better primary care system. However, these newly formed teamlets have little or n   training in how to work together as an interdisciplinary unit. Additionally, health professional trainees are often present and they must know how to work in well-functioning teams. Our VAIL innovation aimed to develop an interactive practice-based educational program to assist PACT teamlets with trainees to learn, improve and coach effective team function.   In this report, we describe how we planned, pilot tested and assessed our educational program and make recommendations to improve future team-based coaching programs.

INNOVATION DESIGN: What were the innovation plans?

We focused our innovation on improving *team function.* Our conceptual model included an adaptation of a widely used framework conceptual model of team function from the business literature that emphasizes the three domains below (1):

- *Task work* is the work that teams perform. It involves understanding the nature of the task and the skills individual team members need to perform the work. In our program, we chose the task work to be a teamlet's quality improvement practices rather than their patient care because it involved a definable knowledge and skill set and because the teamlets initial task of integrating their work as a team is an improvement process at heart.

- *Team work* involves the steps or processes that team members use to coordinate their actions.   We defined this aspect of team function as specific interpersonal communication behaviors used by teamlet members in order to perform their work together.
- *Team processes* are the structures that enable team members to coordinate their work. In our case, this meant protected time for team meetings and effective meeting processes.

For the content of the three domains, our conceptual model drew on the literature on quality improvement (2), relationship-centered communication (3, 4) and effective meeting practices (5-9). We chose *practice-coaching* methods to deliver the innovation to the participating teams (10, 11).

 The intervention planning, tool development, piloting, and refining was planned to take place over 8 months. Curricular planning and tool development corresponded to key behaviors we hoped our learners would acquire in each of the three areas of our curriculum:

- Six QI behaviors - setting aims, identifying problems, establishing measures of improvement, selecting changes, testing changes by using PDSA cycles, and implementing changes.
- Nine team communication behaviors - active listening, trust building, managing emotions, making decisions by consensus, role definition, holding members accountable, giving feedback, receiving feedback, and supporting change in others.
- Eight team meeting processes - setting and following ground rules, clarifying meeting aims, reviewing and assigning meeting roles, negotiating agenda and time allotments, working through agenda by discussing information, reviewing the meeting actions, planning the next actions, evaluating the meeting

The intervention was structured to include five in-person sessions, each two hours in length, with the teamlet at its facility: one for engagement, another to perform the needs assessment; two for coaching; and one at the end for summary and evaluation. Four conference calls (one hour in length) with the teamlet leaders occurred after the teamlet coaching sessions and these were completed before the final evaluation session.

Key intervention activities included:
- Engagement of participating teamlet members and their respective administrative supervisors for motivation building and understanding of the innovation.

- An assessment of team function needs for each teamlet at the beginning;
- Collaborative discussion with each teamlet of the assessment findings and corresponding learning goals for the intervention;
- Coaching for knowledge and skill building in communication, meeting, and QI practices tailored to each teamlet's identified needs;
- Subsequent hand-off of the PACT coaching to the teamlet leaders with monthly conference calls to support the PACT teamlet leaders in leadership and coaching skills to continue team function improvement.

Prior to these activities and with intervention faculty assistance, the senior administrator at each of the 3 VAIL-PCC demonstration sites was asked to recruit one volunteer PACT teamlet and to assure that a one-hour time slot for weekly team meetings would be protected from other patient-care duties and dedicated to QI.

EVALUATION DESIGN: What was the evaluation plan?

We designed a formative evaluation with the purpose of providing information that would guide program improvement to program developers and administrators (12). We documented, assessed, and reassessed the innovation and its implementation throughout the course of the intervention, including the contextual challenges, adaptations, and responses. Since the focus was on the early stages of program development and the participant samples were small; the evaluation was not intended as summative, but we did monitor the effectiveness and impact within these initial samples. To monitor effectiveness, we followed a well-established education evaluation framework (13) that focused on four levels of effectiveness: 1) the reactions of the trainees to the program; 2) their learning (knowledge and skills); 3) change in their behavior; and 4) results in terms of program-related outcomes. We also focused the formative evaluation on key aspects of the curricular design (the triple focus on team relationships, team meeting processes, and quality improvement and the coaching strategy) and the implementation approach (protected time, delivery structure, leadership, team composition, and contextual strengths and challenges.)

The evaluation planned to collect and triangulate both quantitative and qualitative data, including self-reported data collected from the participants (teamlet members and administrators) through interviews, questionnaires, and course evaluation forms; coach assessments synthesized from data collected through visit and conference call observation; and results from the relational coordination survey (RCS) administered to teamlet members before and after the intervention. The RCS is a validated 7-question survey that measures team communication and relationships (14).   It has

been used to measure improvement in team coordination and has been associated with positive changes in quality of care, lower costs, and improved satisfaction among patients and clinicians (15).

INNOVATION IMPLEMENTATION: What did we do?

Implementation of the team function intervention, including development, piloting, and refining, took 11 months to complete (3 months longer than originally planned).   The implementation closely followed the structure that was planned. For each site, the coaches provided five in-person coaching sessions to the teamlet and four coaching calls to the teamlet leaders. The in-person sessions included:

- One engagement meeting to explain and discuss the intervention, identify an area of improvement, and to solicit input and support of the teamlet members and site leadership,
- One needs assessment visit to get a "snapshot " of each teamlet's functioning needs through observation of a teamlet QI meeting, interviews with teamlet members, and administration of the Relational Coordination Survey,
- session in which a summary of the results of the needs assessment was presented to the teamlet and learning needs were collaboratively identified during the first half of the session. Coaching of specific skills in communication, meeting, and QI were initiated in the second half of the session to address these needs.
- Another coaching session targeted to the reminder of the group's learning needs.
- final session that included observation and interviews to get a follow-up "snapshot" of the teamlet's functioning and a joint evaluation and feedback discussion.

The engagement session was one hour in length and the other sessions were two hours. Multiple tools (e.g., handouts, exercises, pocket guides) were provided throughout the intervention.
The four coaching calls began by asking the team leaders to provide an update on the teamlet's meetings, relationships, and QI activities and to specify what they would like to work on. The coaches then responded to these requests. The calls were one hour in length at one site and a half-hour at the other site.

INNOVATION EVALUATION: What did we find? What changes do we recommend?

Our innovation pilot was intensive and small. We present our key observations based on this experience, and discuss their possible implications for future efforts within the VA to facilitate team communication and improve team care within PACT. Detailed curricular recommendations are also are provided. Neither the participant numbers (2 teamlets with 6 members each) nor the evaluation design (pre-post with no comparison group), however, allows us to generalize to other VA teamlets with any degree of confidence.

Was it effective?

Evaluation findings at the two participating sites suggest that the TE intervention was effective in improving team function in some, but not all, respects. summary of our findings follows.

Participant Reactions: In this section of the evaluation, participants assessed the acceptability of course content and structure and the effectiveness of the coaching practices. Most teamlet participants in the TE interventions were highly satisfied with the quality of the course and found the content useful and interesting. One teamlet consistently had more positive reactions, but both generally were positive. Participants liked that the coaches came to them (on-site coaching). They rated all coaching activities as useful, very useful or extremely useful. The general coaching practices that participants found most helpful were those that enhanced motivation, provided education and offered encouragement. Other coaching activities valued highly by either site were: learning QI skills and processes, facilitation of discussion to elicit ideas for change; encouragement of goals; and help to set priorities. The least effective aspect of coaching was in providing links to external sources and tools.

Participant Learning: Teamlet members generally exhibited low levels of knowledge and skills in all three areas of team functioning (team meetings, relationships, and QI processes) when TEX began. At the end, they reported that they had gained knowledge and skills, but the specifics varied among the different respondents. They particularly reported increased awareness and attention to interpersonal dynamics including: 1) being mindful of others; 2) emotion management; 3) active listening to team members; and 4) communication during clinical days and at other times to share goals, successes, and frustrations. The participants' discussion of lessons learned suggested that their mindset had progressed from "individual responsibilities" to "team responsibilities." Regarding QI processes, site 1 teamlet's discussion suggested that they did not come to understand or accept the ongoing nature of QI, but rather retained the view of it as one-time project that they had completed at the point the TEX intervention ended. The other teamlet, o the other hand,

expressed clear recognition that they would continue to have work to do and room for improvement.

Behavior Change: Some behavior change was evident. The RC survey results suggested a trend towards improvement in relational coordination, particularly at site 2. The coaches also observed positive behavior change at this site. Improvements were noted in the teamlet's ability to 1) make decisions collaboratively; 2) receive feedback; 3) manage emotions; and 4) support change in others. In the their final assessment, both teamlets reported improvement in their team relationship behaviors, team meeting behaviors, and QI behaviors, with site 2 consistently reporting higher increases.   By coach assessment, however, only site 2 changed how they conducted meetings; site 1 never coalesced as a team. Performance of QI processes proved difficult for both teams. One team (site 2) did make headway but not across all QI processes. The other team made little headway.

QI Results: Structural or process redesigns resulted, with some reported improvement in workflow. At site 1, the structural redesigns that did not require much teamlet participation or decision making (new electronic consult and schedule of availability) appeared easier to implement than the workflow process changes at site 2 that necessitated collaboration among multiple team members and new ways of relating to each other (new care algorithm).

Was it feasible?

While the original plans called for three teamlets, it only was possible to recruit two. Administrators at one of the VAIL-PCC Demonstration sites were unable to designate a team or assure protected time. Teamlet uptake of the intervention took longer than expected due to clinical demands, vacations and possibly motivation.

Implementation of this coaching intervention proved feasible in the two participating sites. Facilitation in the application of all three coaching components (motivation, education and consultation) was essential for the success of this intervention. Other necessary coaching skills were in team relationship behaviors, especially to identify and address factors indicative of teamlet dysfunction.

Site and teamlet leadership and staff motivation proved to be implementation facilitators in some instances. Some of the challenges to smoother implementation included the ongoing time pressures on the teamlet members (even with protected time), staffing disruptions, absence of organizational

rewards for team performance, minimal job requirements for teamwork skills, variation in job accountability (different silos), variation in leadership interest and monitoring, and lack of mechanisms to support teams. Support from site administrators, especially to assist teamlets with cross-departmental role, staffing, and motivation-related problems was needed.

How could the innovation be improved?

In addition to effectiveness and feasibility, we examined how the curricular and delivery elements of the innovation performed in this pilot test. Based on these findings and observations, we offer a number of recommendations for innovation improvement. These recommendations, along with the corresponding findings and observations, are presented in Table 1. The key findings and observations are derived from the interviews, survey, course evaluation forms, coach assessments synthesized from data collected through visit and conference call observation. The coaches independently developed the observations and recommendations and then discussed and arrived at the final lists in Table 1 by consensus.

revised curriculum, based on these recommendations, follows in Table 2.

Table 1. Key Findings and Recommendations for Future Curriculum and Implementation Approach

TEX Design Characteristic:	Key Findings and Observations	Key Recommendations
CURRICULUM		
Triple focus	• The needs assessment indicated that teamlet had needs in all 3 areas of team function • The teamlet responded positively to the course and indicated improvement in all areas • Mastery of meeting processes was beneficial to learning QI and team communication • Simultaneous learning of team relationship and QI behaviors were complimentary	• Continue with triple focus • Emphasize mastery of team meeting processes first
Team Meeting Processes	• The site that mastered the team meeting process exhibited more success in coalescing as team • Following ground rules does not come naturally	• Introduce the importance of meeting practices early • Emphasize continued application of ground rules during all teamlet activities
Team Relationships	• While the teamlets showed improvements in many relationship skills, they needed more time and practice • Communication between teamlet members is often absent and sometimes actively resisted • Especially difficult communication behaviors were: trust building, defining roles, collaborative decision-making, giving and receiving feedback, and holding teamlet members accountable • Teamlets did not understand or believe the feedback from the RC scale	• Incorporate more time for teamlet members to practice the relationship skills we identified as most difficult. • Increase time for communication skills facilitation and modeling • Expand the relationship skills exercises to address all 9 behaviors • Eliminate use of the RC scale for feedback
Quality Improvement	• The mindset of continuous improvement is lacking and even resisted, seemingly due to lack of knowledge of the QI process, time pressures of clinical work and resistance to change. • External motivating factors were lacking for QI • Teamlet ha a poor grasp of how to conduct QI processes • They avoided selecting and using measures of improvement • Improving work flow processes among all teamlet member called for high levels of relationship skills improvement efforts that only involved 1 or members side-steppe the team-building focus • Teamlets struggled with the ongoing nature of QI, as opposed to it being one-time project • Resolving barriers as they emerged during the QI process required perseverance, but did lead to successful tests of change • Teamlets assessed their own QI skills higher that	• Encourage administrators to: a) Set the tone: "From now on, we're going to fix problems not ignore them; and b) Set expectation that problem-solving barriers is part of QI. c) Identify timelines and venues for teamlets to share QI work • Include a brainstorm session to identify problems and solutions early on to motivate teamlet members and engage them in QI • Encourage QI focus on work flow redesign that involves the whole team • Create exercises/tools to practice each PDSA step

	did the coaches	

Coaching	• All coaching components (motivational, educational and consultative) are useful.
	• Both teamlets required extensive follow-up coaching to make timely progress on their QI activities and relationship building.
	• Factors indicative of teamlet dysfunction were
	  1) Lack of commitment
	  2) Teams not meeting regularly
	  3) Interpersonal relationship tension
	  4) Resistance to examining work processes
	  5) Resistance to receiving feedback
	  6) Lack of response to coaches' suggestions
	• Successful coaching methods included:
	  1) Small group interactive workshop format
	  2) Modeling
	  3) Handouts - QI and Team Meeting Processes
	  4) Post-it exercises (equalized member input)
	  5) Coach modeling of behaviors in all 3 areas
	  6) Facilitated team meetings
	  7) Teamlet member participation in agenda setting
		• Continue to use all three coaching components (motivation, education and consultation)
		• Intensify and sequence coaching:
		  1) Introduce trust-building activities early and continue them
		  2) Emphasize meeting processes early especially ground rules, active listening, role definitions
		  3) Emphasize QI skills once relationship-building is underway
		• Coaches should b on the lookout for signs of teamlet dysfunction and should address them by modeling the difficult communication skills we identified above
		• Continue successful coaching methods

IMPLEMENTATION		

Protected time	• Protected time is difficult to obtain but necessary
	• Effective use of protected time required facilitation and monitoring.
	• The boundary spanners (pharmacists and psychologists) could not always participate due to lack of protected time
		• Administrative support is needed to ensure that protected time is:
		  1) Granted (including for the boundary spanners)
		  2) Effectively used

Structure	• The faculty found the tools in the three areas useful for needs assessment and evaluation
	• Participants had positive feedback on course structure, particularly:
	  1) Location at the clinical practice
	  2) Small group workshop format
	  3) Monthly coaching calls with leaders
	  4) Opportunity to apply lessons during clinical work
	• Onsite sessions allowed coaches to observe and engage teamlet members' interactions
	• The coaches used in-person sessions primarily to motivate and educat and the calls to provide consultation and leadership education to leaders
	• The needs assessment session was resource intensive for all parties. Teamlets found it difficult to prioritize the results
	• Workshops and calls spaced few weeks apart were more animated and productive; interest and
		• Continue to use the behavior-focused tools in the future
		• Continue both the in-person sessions with the teamlet and phone calls with the leaders and alternate them
		• Schedule sessions every to 3 weeks
		• Engage the team leader early to initiate leadership skill learning an assessment of the teamlet's current relationships, meeting processes, and QI experience
		• Incorporate needs assessment and feedback into all sessions and eliminate the targeted needs assessment session

	involvement waned when spacing was longer	• Se revised curriculum below for the next pilot.
Administrative Leadership	• The teamlets required administrative support in the areas of team function. It would have been helpful for the administrators to have more background o the intervention. • Expectations and incentives for presentation and sharing of results were lacking • Loss of a teamlet member hindered the progress of member relationships	• Ad a pre-course session with administrators – see Table 2

Teamlet Leadership	• Co-leadership with PCP and other health professional provided built-in leadership support, and helped to share the burden of leading and organizing the team.
	• The role of team leader seemed to be new and undefined.
	• Team leaders required support for their new role
	• The team leaders had particularly difficult time managing dysfunctional team factors (see above)
	• Teamlet leaders needed specific skills to perform the following leadership activities:
	  1) Define common goals, roles and approaches;
	  2) Focus and coordinate team activities;
	  3) Assess team performance giv frequent feedback and provide mentoring;
	  4) Motivate team members for improvement;
	  5) Establish positive team atmosphere;
	  6) Ask for support and resources from supervisors
	  7) Model good relationship skills
		• Encourage paired teamlet leadership.
		• Develop and coach a specific curriculum for teamlet leaders based o the needs we observed
		• Continue the coaching calls
		• Encourage teamlet leaders to address dysfunctional team factors and work with their administrators to problem solve.

Teamlet Trainees	• The trainee who was embedded in all teamlet activities had a positive learning experience, demonstrated learning in all 3 team functions, and served as role model for the teamlet. • Trainees facilitated positive relationships and learning through curiosity and lack of judgment. • Trainees have energy and time for QI work and often led these efforts.	• Include trainees in future training sessions when possible • Select trainees who are active members of practicing teamlets • Take advantage of opportunities for trainees to lead QI efforts, motivate other team members and serve as role models

Context	• We observed that a number of contextual challenges to team function were evident:
	  1) Tension between standardizatio of member roles and the need to be flexible to team needs
	  2) Lack of cross-disciplinary accountability
	  3) Lack of team incentives and rewards
	  4) Workload stress is apparent in teamlet members, but may not be to administrators
	• Psychological safety may be an issue for some
	• Administrators' view of team culture were more rosy than frontline teamlet members'
		• Encourage administrators to better support team function by addressing the barriers in the work environment that we observed.

Table 2. Revised Curriculum Based on Recommendations

All sessions will be 2 hours. They will occur every 2 – 3 weeks to allow the teamlets to apply lessons and practice skills during patient care and at team meetings

Pre-course Session to Engage Teamlet Supervisors/Administrators: – This will be a session to motivate, engage and prepare site administrators for their role in teamlet learning and improvement. Their role to be discussed interactively:

- Get buy-in for the intervention plan, especially the protected meeting time
- Explain the intervention, especially the triple focus of the curriculum;
- Set expectations in all 3 areas and follow-u to assure teamlet accountability
- Stay abreast of progress in all 3 areas and problem solve with teamlet leaders as needed.
- Assure constancy of team composition and replace team members without delay

Session 1: Mock Team Meeting, Course Introduction and Faculty Observation – the session would be organized as if it were a team meeting. After the session, the faculty will assess the team's meeting and relationship skills using developed checklists. The "meeting" agenda would include:

1. Assign Team Meeting Roles
2. Introduction to the Course – Overview, motivation, TEX structure. Objectives:
    o Learn how the course will proceed
    o Learn general concepts of the CCM and QI models, why they are important in PACT
    o Learn and practice a model for relationship-centered team meetings
    o Identify how our relationships affect the quality of our teamwork.
3. Participant Introductions and Learning Goals
4. What are the "Curve Balls" of Team Meetings?
5. Ground Rules
6. Brief Review of a Model for Relationship-Centered Team Meetings
7. Team Meeting Role Play
8. Debrief the Role Play and Discuss Lessons Learned

Coaching Call   1: This will be with the team leader(s) to debrief, identify how the team currently functions, brainstorm ideas for how to proceed as leader, and review concepts of PACT leadership:

- Define common goals, roles and approaches to the work;
- Focus and coordinate team activities

- Promote individual and group accountability by frequent assessment and feedback
- Assess team member needs and teach/mentor them accordingly;
- Motivate team members for improvement;
- Establish a positive team atmosphere;
- Seek support and resources from supervisors when needed
- Model good relationship skills
- Homework – read CCM articles

Session 2: Chronic Care Management I and Patient-Centered Care - The teamlet will have completed the ACIC evaluation and returned it to the faculty before the meeting. Goals of the session:

- Understand the Chronic Care Management Model and how it applies to your care of patients
- Define patient self-management
- Learn knowledge and practice communication skills to support collaborative decision-making
- Practice how to assess and document patients' self-management needs
- Understand how to involve patients and families in the care

Session 3: Chronic Care Management II – Goals of the session:

- Define the components of delivery system design for CCM: pre-visit assessment skills and tools
- Learn a model for "Planned Diabetes Visits"
- Learn and plan for "Group Diabetes Visits"
- Brainstorm: How can we apply the CCM to our care of patients with Diabetes?
- Homework: At team meetings develop a process map and prioritize initial actions

Session 4: Quality Improvement – Goals of the session:

- Adopt the mindset of continuous quality improvement Specify the central role of Quality Improvement in Primary Care reform and PACT
- Review your targeted areas for improvement for CCM
- Learn QI Skills to Improve your PACT work:
  o IHI Model for improvement
  o Practice writing an SMMART aim statement
  o Brainstorm measures – existing ones and easy ones to collect
  o Review process map
  o Brainstorm reasons for failure and create a tally sheet to monitor
  o Design a small test of change and apply before next session

o   Homework: Relationship-centered communication processes

Coaching Call   2: This will be with the team leader(s) to debrief, identify how the team currently functions, brainstorm ideas for how to proceed as leader, and review concepts of PACT leadership

Session 5: Relationship-Centered Communication I – Goals of the session:
- Learn the model of Relationship-centered Care
- Understand the links between patient-centered communication and team function
- Understand the imperative for self-care an   stress management in PACT
- Practice mindful interpersonal communication strategies with team members
- Define team member CCM roles for Diabetic patients using relationship-centered communication strategies and collaborative decision-making

Coaching Call   3: This will be with the team leader(s) to debrief, identify how the team currently functions, brainstorm ideas for how to proceed as leader, and review concepts of PACT leadership.

Session 6: Relationship-Centered Communication II – Goals of the session:
- Describe a patient-centered care environment
- Gain insight into personal communication strengths and challenges
- Learn and practice communication skills relevant to patients and team members
  - Respond to emotions
  - Explore values, beliefs and fears
  - Giving and receiving feedback
  - Holding others accountable to role responsibilities

Coaching Call   4: This will be with the team leader(s) to debrief, identify how the team currently functions, brainstorm ideas for how to proceed as leader, and review concepts of PACT leadership

Session 7: Sharing Best Practices – Goals of the session:
- Learn and practice preparing   presentation of   PDSA improvement process
- Practice delivering a presentation
- Review guidelines for publication of QI results

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ACKNOWLEDGEMENTS

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